2009

Reproductive tourism : the case of India, a feminist critical discourse analysis of Indian gestational surrogacy tourism

Grant, Lyndsay

Reproductive Tourism: The Case of India

A Feminist Critical Discourse Analysis of Indian Gestational Surrogacy Tourism

By: Lyndsay Grant
Advisor: Dr. Rachel Ariss
Department of Sociology
Lakehead University
Thunder Bay, Ontario

Submitted to the Faculty of Graduate Studies in partial fulfillment of the requirements for a Masters of Arts Degree in Sociology with a specialization in Women's Studies

September, 2009

Acknowledgements

I would like to thank Dr. Rachel Ariss, my thesis advisor, for her contributions and dedication throughout the thesis process. Her guidance and direction has been unmatched and is greatly appreciated. I would also like to thank my thesis committee, Dr. Lori Chambers and Dr. Tony Puddephatt for their insight and direction. Finally, I would like to thank my parents, Bonnie and Dave, Jim and Nan and Ed, my family and my partner, Mike. I would not have been able to do this with out their continual encouragement and support.

Abstract

Within an increasingly globalized medical community, people have begun to travel outside of their own geographic locations in order to obtain various medical procedures. Reproductive tourism is one of the latest developments of health tourism and can be understood as individuals obtaining some type of reproductive assistance from outside of their home jurisdiction. India has become a major reproductive tourist destination for foreign couples seeking gestational surrogacy services. I refer to this situation as *Indian gestational surrogacy tourism.* This paper uses a feminist critical discourse analysis in order to analyze media representation of Indian gestational surrogacy tourism. Indian gestational surrogacy tourism can be understood as being presented as an *ethical master narrative* within which discursive frames are used to argue either for or against Indian gestational surrogacy tourism. Those presenting this as a positive development use discursive frames that promote India as an ideal destination for gestational surrogacy services. Conversely, those who are critical of this practice use discursive frames that present legal, ethical and dehumanization concerns.

Reproductive Tourism: The Case of India
A Feminist Critical Discourse Analysis of Indian Gestational Surrogacy Tourism

Table of Contents

Reproductive Tourism: The Case of India
A Feminist Critical Discourse Analysis of Indian Gestational Surrogacy Tourism

Introduction

Recently, as indicated by media accounts, there has been growing social concern about reproductive tourism: "...the movement of citizens to another state or jurisdiction to obtain specific types of medical assistance in reproduction that they cannot receive at home" (Pennings, 2004: 2690), or that they cannot afford at home. Reproductive tourism can be understood as a branch of health tourism and as a result of globalization (Blyth and Farrand, 2005: 96). Media accounts suggest that there has been an increase in the number of people from the West who have chosen to go overseas in order to obtain fertility treatments. Western couples have been traveling to India in order to hire Indian women to act as gestational surrogate mothers (Haworth, 2008; Nijher, 2008; Warner, 2008). This paper seeks to understand how reproductive tourism, as it relates to India, is presented in the discourse. I aim to uncover the master narrative representation of the discourse presenting this issue and ultimately to gain an understanding of why this particular instance of reproductive tourism has developed.

Surrogacy can be defined as "the practice of surrogate motherhood" and a surrogate mother can be defined as "a woman who bears a child for another woman" (Barber et. al., 2005: 853). Traditional ('straight', 'complete', 'genetic-gestational') surrogacy occurs when the surrogate mother's ovum is used and fertilized by the sperm of the male who has solicited the surrogate mother. In gestational surrogacy, the focus of

this paper, the surrogate mother has no genetic relation to the child she gestates. Both the ovum and the sperm come from the commissioning couple and are fertilized through in vitro fertilization (IVF) and implanted into the womb of the surrogate mother. In some instances this procedure is done by using either or both donor sperm and egg (Blyth and Farrand, 2005: 108-109). Butler's definition of surrogacy includes an agreement that ensures that the child produced out of such an agreement will be raised by the commissioning parents (Butler, 2003: 3). According to Anleu, in surrogacy contractual arrangements, the woman who is to act as the gestational surrogate mother agrees to "undergo a pregnancy for a couple" and agrees to then give the child 'back' to the commissioning couple after birth (Anleu 33). Commercial surrogacy can be understood as paying a woman not just to compensate her for surrogacy, but to the extent that she is actually incurring a financial gain for gestating, giving birth to the child and for relinquishing all parental rights to the commissioning parents (Wilkinson, 2003: 169-170).

The use of fertility treatments is a growing business. Underlying ideological beliefs surrounding motherhood and infertility and the preference of genetic children (Ragoné, 2000: 59; see also Rothman, 2000: 45; Franklin, 1997: 142) in the West have led to the development of new and assisted reproductive technologies. The importance placed on genetic reproduction has encouraged the continual growth of this industry in the West. It is estimated that in 2004 in the United States of America, the fertility industry had become a nearly three billion dollar industry with over one million

Americans undergoing some type of fertility treatment (Spar, 2006: 3)[1]. The "Commerce of Conception" is an attractive market in which the supply is very limited due to the medical expertise needed to perform the services, but this is contrasted with an immense demand by people desperate "to buy" the product (Spar, 2006: 2-4)[2]. Since potential parents want a genetically related child, there can be no *knock off genes* (substitutions) (Spar, 2006: 4, see also Stanworth, 1987: 20) and adoption is out of the question (Spar, 2006: 4). Thus gestational surrogacy has become an ideal option for infertile couples. Emphasis on the importance of genetically related children has led many to do whatever possible in order to obtain "the real thing", "[t]hey will mortgage their houses, sell their cars, [and] deplete the family savings" (Spar, 2006: 4). While providers of fertility treatments often deemphasize the monetary aspect of their trade (Spar, 2006: 3), the fertility industry is undeniably a business devoted to the production of noncommercial products: children (Spar, 2006: 3).

Gestational surrogacy is noted to cost up to $80,000 In the United States (Warner, 2008: 1). In addition, American legal issues surrounding surrogacy are complicated. Traditional surrogate mothers are still at times afforded legal rights to the child until they officially sign these rights over (Warner, 2008: 1), while typically gestational surrogate mothers (as in the *Johnson v. Calvert* case in California) have no legal rights to the child to whom they have given birth. While commercial surrogacy is legal in the United States,

---

[1] Spar reports that the revenue from IVF in the United States was over one million dollars (US) in 2004, the revenue from fertility drugs adds up to over 1.3 million (US), diagnostic test a $374, 900, donor eggs $37,773 (US), donor sperm $74,380 and surrogate carriers $27,400 (US) (Spar, 2006: 3).

[2] It is currently suggested that only about thirty six percent of women who are defined as infertile seek treatment (Spar, 2006: 32).

some Western nations, such as Canada, have made it illegal (*Assisted Human Reproduction Act 2004 s. 6).*

Hence, due to pricing and legal concerns, people have begun traveling to underdeveloped and developed countries in order to obtain various medical forms of reproductive assistance. For instance, while the Barbados Fertility Center[3] provides local fertility services, with a particular focus on in-vitro fertilization, their website also promotes their center to foreign couples such as Canadians, Americans, people from the United Kingdom and other European countries. Additionally, news reports have noted that couples from Australia, France, Italy and Sweden are traveling to Canada (non-commercial surrogacy as commercial surrogacy is illegal in Canada) and the United States of America in order to obtain gestational surrogate mothers to carry biologically related children for the intended parents. Such reports note that gestational surrogacy services are illegal in these countries, thus pushing desperate couples to travel to North American destinations in order to obtain genetically related children (Gazze, 2007: 1; Gazze 2009: 1).

A new reproductive tourist destination has developed in the third world. Media accounts have reported that India is developing a reproductive tourist industry particularly focused on offering the services of gestational surrogate mothers. According to multiple media accounts, surrogacy for foreign parents was pioneered by Dr. Nayna Patel in 2003 (Nolen, 2009(a): 2; Jones, 2004: 2; Horsey, 2004: 1; Roy, date unknown: 2; Bhatia and Oakeshott, date unknown: 1). The Indian gestational surrogacy industry can

[3] (http://www.barbadosivf.org)

be understood as largely developing out of a particular gestational surrogacy case, presided over by Dr. Patel, at the Akanksha Infertility Clinic. In this surrogacy arrangement Lata Nagla, a non-resident Indian woman living in Ilford, Essex, was medically unable to carry children. Her mother, Rhadha, who lived in Gujarat in India agreed to act as an altruistic gestational surrogate mother for her daughter and her daughter's husband (Aakash Nagla) (Horsey, 2004:1). The genetic maternal grandmother successfully gave birth to twins for her daughter (Roy, date unknown: 1-2). This particular case of "Supergran surrogacy" (Horsey, 2004: 1) received world wide attention which put the Akanksha Infertility Clinic and Dr. Patel in the spotlight (Mendick and Bhatia, 2009: 1). The world wide coverage of this unique situation led individuals to contact Dr. Patel, who is reported as having been "inundated with requests for surrogacy" (Haworth, 2008: 1). Indian gestational surrogacy tourism can be understood as developing out of an altruistic situation in which all parties involved were ethnically Indian. However, this business has since evolved into Indian gestational surrogate mothers being used by not only infertile Indian couples (resident and non-resident) but also non-Indian foreign couples, typically from wealthier nations.

However, it is only because surrogacy in India was deemed legal that the Naglas were even allowed to partake in a gestational surrogacy arrangement. In 2002 commercial surrogacy was legalized in India (Gentleman, 2008: 1) and in 2005 the Indian Council of Medical Research created the *National Guidelines For Accreditation, Supervision, and Regulations of ART Clinics in India*[4] which puts forth surrogacy

[4] This can be downloaded from the ICMR website: http://icmr.nic.in/

regulations (Singh, 2007: 1). In addition, according to the *Ethical Guidelines for Biomedical Research on Human Participants* put forth by the Indian Council of Medical Research, the contracting or intended parents have been constructed as having the priority of parental rights, "[t]he intending parents should have a preferential right to adopt the child subject to six week's postpartum delay for necessary maternal consent" (2006: 102). Surrogacy contracts are signed in both Western nations and India by the gestational surrogate mother and the commissioning couple. In most cases, these contracts help to ensure that the resulting child will be 'returned' to the commissioning parents and provide financial compensation for the surrogate mother.

Not only is gestational surrogacy legal in India, but the prices are also more economical, with suggestion of a total cost of only $12,000US (Haworth, 2008: 1; Stephenson, 2009: 189). Furthermore, India, while still considered a third world nation, has an advanced medical infrastructure and a large English speaking population. Thus, Indian women are being used to carry "white" or Western children generally for heterosexual couples who are unable (or possibly unwilling) to carry a child for themselves. This process has been termed many things including "reproductive tourism", "wombs for rent", the "outsourcing of the womb", "procreative tourism", and "reproductive outsourcing". I will refer to this process as *Indian gestational surrogacy tourism* for the purpose of this thesis.

Gestational surrogacy separates the conception components of human reproduction and this has helped to create a larger and increasingly profitatable surrogacy market as this has, "...created considerably more choice for the consumers of

reproductive services and reduced the risks and ambiguity that had surrounded traditional surrogacy" (2006: 85). Thus it is hardly surprising that the, "...disaggregation of the supply side also allowed the surrogacy market to go slowly and surreptitiously go global" (Spar, 2006: 85). In line with American and Western fertility business' as well as sexual tourism and health tourism, Indian gestational surrogacy tourism has become 'big business'. It is currently suggested that there are about sixty centers in India which offer ARTs (Butler, 2003: 3). In India, the fertility industry has been estimated as a $445 million a year business (Oberoi, 2009: 1). According to Gentleman, "[c]linics that provide surrogate mothers for foreigners say they have recently been inundated with requests from the United States and Europe, as word spreads of India's mix of skilled medical professionals, relatively liberal laws and low prices" (2008: 1). Thus fertility treatment has become an ever growing industry in India.

Indian gestational surrogacy tourism appears to have developed as an alternative to Westernized gestational surrogacy tourism and appears to be in competition with the American surrogacy industry. The use of Indian gestational surrogate mothers by foreign, typically white, wealthy, Western couples warrants examination. An understanding of this begins with an examination of the underlying Western ideological beliefs which have worked towards not only the development of assisted reproductive technologies (ARTs), but also the globalization of these technologies. The development of ARTs and their globalization have ultimately helped in the development of reproductive tourism particularly as it relates to India.

Chapter one begins with a discussion of the cultural context for reproductive tourism Here, I discuss the importance of motherhood and parenthood in Western societies. Both social constructions of motherhood and the undesirability of infertility are underlying Western ideological beliefs which have played an important role in the creation of new and assisted reproductive technologies. In turn, the creation of ARTs has worked to reinforce the cultural importance placed on motherhood and parenthood. Next I turn to a specific focus of globalization and the development of reproductive tourism. The final section of this chapter is an examination of the politics of gestational surrogacy. Here I examine the dominant concerns and critiques of gestational surrogacy including race and class, the exploitation and the commodification of the body as well as issues of choice. Finally various legislative and legal concerns surrounding gestational surrogacy are considered at both at the national and international levels.

Chapter two explains my methodological approach. The chosen method of analysis of Indian gestational surrogacy tourism is a feminist critical discourse analysis. The purpose of this paper is to explore and analyze the practice of Western individuals using Indian women as gestational surrogate mothers. The ultimate goal of this paper is an understanding of the master narrative (Downe, 2006) of 'outsourcing the womb' to India as well as the reasons for the development of this practice. Such an analysis has proven useful in understanding the different ways that the public thinks about and understands Indian gestational surrogacy tourism.

Chapters three and four are my analysis of Indian gestational surrogacy tourism as presented in public discourse. Indian gestational surrogacy tourism can be understood

as being presented as an ethical debate, which either argues for or against the use of Indian gestational surrogate mothers. Hence I refer to the master narrative of reproductive tourism as it relates to Indian gestational surrogacy services as an *ethical master narrative*. Thus in chapter three, I discuss the 'for' aspects of the ethical master narrative of Indian gestational surrogacy tourism and the construction of the Indian gestational surrogate mothers as well as the commissioning parents. This is followed by an analysis of socio-cultural factors that contribute to decisions to use Indian gestational surrogate mothers, such as the naturalization of reproduction, desperation, constructions of hope and globalization. Finally this chapter examines how India has been promoted as a worthwhile destination for fertility tourists.

Chapter four turns to a focus on the 'against' side of the ethical master narrative of Indian gestational surrogacy tourism, including issues of the nationality of the children born out of such arrangements as well as familial reformations. Another critique of Indian gestational surrogacy is the potential exploitation of the Indian women and the development of a business which commodifies the bodies of Indian women. Furthermore, issues of dehumanization, choice, fetal focus, and the monitoring of the Indian gestational surrogate mothers are also explored.

Finally, a concluding discussion will be presented in order to review the findings as well as to discuss these findings. Furthermore, how this information can be useful will be discussed. I will then make suggestions for future research in this area. It appears that very little has been written relating reproductive tourism in academia, likely due to the very new nature of this new form of health tourism. Reproductive tourism, both in

general and in the specific case of India, is on the rise. Such a development has many real world, social and legal affects on individuals, countries and the globe. With an expectation that this industry will continue to grow, it will affect increasing numbers of people and has the potential to change Western understandings of medical infertility options. There is generally very little understanding of reproductive tourism as is relates to India, and thus research needs to be conducted in order to understand this development. Research focusing on how the key aspects of Indian gestational surrogacy tourism are represented and debated in the popular media can increase understanding of how the situation developed, and potentially help guide decision makers as to how this situation can and should be dealt with.

Chapter One:

The Cultural Context for Reproductive Tourism and The Politics of Gestational Surrogacy

The Cultural Context for Reproductive Tourism

In examining Indian gestational surrogacy, it is important to understand Western constructs of motherhood and infertility. Western culture places great importance on the role of motherhood and fertility to the extent that technologies have been developed in order to assist with conception as well as to aid those termed as 'infertile' to produce genetically related children. The discourses surrounding motherhood and issues of fertility/infertility and ARTs work to reinforce the importance of fertility and motherhood and to promote and legitimatize the use of technology in achieving parenthood. The strong desire to have genetically related children has in part developed out of cultural expectations that family members are "blood related". Reproduction is constructed as vital in many women's lives and this can be used to help explain their use of ARTs such as gestational surrogacy in order to obtain biologically related children.

These technologies, however, are not exclusive to the Westernized world, but also exist in less developed nations such as India. In such a nation, like many other products and services, these technologies are available at much lower prices than in the West. Lower prices coupled with a highly developed medical infrastructure have made India a popular destination for Western individuals who wish to use such technologies. The strong desire to have a biologically related child has driven such individuals to cross borders and oceans in order to achieve biological parenthood. This chapter examines how

infertility, motherhood and technology are discussed in Western society in order to explore what it is in Western culture that supports the acceptability of Western couples traveling to India in order to obtain a genetically related child.

Motherhood

In many traditional societies women who gave birth were revered and understood as, "...following the ways of both God and nature", however, when they were unable to bear a child,"...life had gone astray" (Spar, 2006: 6). In contemporary society, whether or not women actually become mothers, motherhood is an important construction and social role. This is particularly strong for married, heterosexual women and this role has come to be expected from women as a normal life direction (Miller, 2005: 48). In the 'natural' trajectory of aging, one is expected to marry and then to have children in order to create a family (Franklin, 1997: 134; Miall, 1986: 268). The desire to be a parent and have children is believed to be a normal part of the natural order (Widge, undated(a): 63, see also Franklin, 1997: 134, Stanworth, 1987: 15) and it is assumed that people want to and will reproduce (Franklin, 1997: 133). Many understand reproduction and motherhood as the central and determining purpose of women's lives (Doyal, 1987: 181). Most women have been taught to expect motherhood to be their most fulfilling role (Doyal, 1987: 184) and it is therefore assumed to be desired above everything by women (Doyal, 1987: 181). Western society continues to maintain patriarchical ideology (Millett, 1970: 25) and within patriarchical ideology, the family is a dominant institution (Millet, 1970: 33). In patriarchical ideology, kinship can only be acknowledged as it relates to the male line (Millett, 1970: 33-34). Thus, in this belief system, the status of

mothers and children are "dependent upon the male" (Millett, 1970: 35). Motherhood is defined in patriarchical terms in order for the continuance of male control. Since women as child bearers are a vulnerability to men (Rothman, 1989: 29-30), patriarchy considers paternity as a fundamental relationship as a means to maintain male kinship lines (Rothman, 1989: 31). In order to maintain the male lines of kinship, men need to control women's sexuality in order to help ensure their genetic connection to children (Rothman, 1989: 31). Out of this come the social ideas of what it means to be a good woman, for instance, one who is not sexually promiscuous and one who is a good mother.

Social constructions of what a 'good' mother is are important. Women are bombarded with various opinions and 'how tos' about mothering by expert, lay and public knowledge (Miller, 2005: 46). Good mothering is, according to Miller,"... premised on ideas of being with children, fulfilling the demands of intensive nurturing, whilst at the same time it involves taking up paid work and providing financially for a child" (Miller, 2005: 55). The Oxford Canadian dictionary includes in its definition of motherhood "having an undisputed inherent goodness" (2005: 540). The definition of the good mother includes a woman who either stays home, or if she does not, experiences feelings of guilt for working outside of the home (Miller, 2005: 55). Furthermore, a 'good' mother is one who avoids risk both during and after pregnancy (Miller, 2005: 48), and thus attends regular medical appointments and religiously follows doctors' advice (Miller, 2005: 49). Thus,"[t]he medicalization of childbearing, in conjunction with the pervasive ideologies and practices that shape expectations of mother[s], can be seen to powerfully reinforce notions of appropriate ways of preparing for becoming a mother and

how a good mother 'naturally' acts" (Miller, 2005: 46-47)[5]. The importance of the role of motherhood contributes to the deeply problematic aspects of infertility for women. I will address this in the following section.

While the construction of motherhood varies between cultures and within different cultural contexts, biological children tend to be preferred (Ragoné, 2000: 59; see also Rothman, 2000: 45; Franklin, 1997: 142). This preference is due to a "powerful cultural theme" surrounding the importance of blood ties (Stanworth, 1987: 20) which places preference on the continuation of genetics through children (Franklin, 1997: 142). Since a child who is genetically related to both parents is highly desirable, it has become the primary reason for continual growth in the popularity of gestational surrogacy (Ragoné, 2000: 60).

Our society tends to privilege the genetic and social connections between mother, father and child over their gestational relationship. Since in Western society ideas of kinship are based on the assumed genetic connection between parent and child, the genetic relationship between parent and child is seen as a 'natural' relationship. Reproductive technologies and gestational surrogates are thus helping create a 'natural' family and this works to normalize the use of ARTs (Ikemoto, 1996: 1027; see also MacDonald, 1994: 88). Yet metaphors relying on concepts of 'the natural' are problematic for women as they are based on patriarchical definitions (MacDonald, 1994: 93). The patriarchical family is presumed to be natural and a basic unit of our society (MacDonald, 1994: 87) and it promotes the idea that reproduction should only take place

[5] A fuller explanation of the culture of motherhood is beyond the scope of this work.

within marriage between heterosexual couples (MacDonald, 1994: 87-88; see also Ikemoto, 1996: 1027, 1028).

Such naturalized views affect women negatively as they presume that a family is only 'real' if there are genetically related children produced. From this view, 'real women' have a natural desire to have children (MacDonald, 1994: 87). Medically, the natural order metaphor of procreation is promoted and understood as one of the basic human physiological functions and a basic human desire, right and need (MacDonald, 1994: 87). Since procreation is considered natural, those who are infertile use this metaphor to legitimize their desire for children as natural and infertility is therefore understood as a disease that inverts that presumed natural order of things (MacDonald, 1994: 87).

This legitimization of the desire for biological children often leads infertile individuals to ARTs in order to cure their 'disease'. ARTs have come to challenge the connection between social and biological motherhood (Markens, 2007: 16). Historically it has been socially expected that a biological mother would also be the social mother. However, with the advent of ARTs, new understandings of kinship have been formed (Sarah Franklin, 1993: 128 in Markens, 2007: 2). Such technologies upset the "traditional" ways of reproduction (Markens, 2007: 16) and motherhood has been fragmented into its genetic, gestational and social aspects (Hammons, 2008: 270; see also Markens, 2007: 16,173; Van Den Akker, 2002: 93; *Johnson v. Calvert*, 1993: 791; Stanworth, 1987: 16, Schwartz, 1994: 241). Some claim that genetic relation should be understood as the basis for motherhood due to a belief that the genetic aspect of

biological motherhood is a lasting link (Hammons, 2008: 272 -278). Others argue that gestating a child is actually a more profound act than a genetic connection (Hammons, 2008: 277) and as such the gestational mother is *the mother* (Hammons, 2008: 271). Still others argue that the primary indicator of motherhood is social motherhood as parenthood is not necessarily dependent upon genetics and biology and reflects women's lifelong socialization (Hammons, 2008: 271-272).

The genetic, gestational and social fragmentation of motherhood enabled by gestational surrogacy has redefined cultural understandings of motherhood. Since there are at least two women who can be defined as the mother of a child born of gestational surrogacy, there is a need for legislation to address this issue and define legal motherhood, particularly, in gestational surrogacy arrangements. The case of *Johnson v. Calvert* brings to light the issue of who is to be considered the natural mother of a child born out of a gestational surrogacy arrangement (Hammons, 2008: 271-272; see also *Johnson v. Calvert,* 1993: 778). This case is significant because it shows how assumptions about physical connection and intention work in socio-cultural understandings of 'mother'. In this case the Calverts, a middle class couple, 'hired' Anna Johnson an African-American, working class woman to gestate an embryo formed from their egg and sperm (Grayson, 2000: 99). Despite agreeing to the terms in the surrogacy contract, including an agreement to relinquish the baby to the Calverts at birth (Grayson, 2000: 99), Johnson took legal action against the Calverts to be declared baby Christopher's mother (Grayson, 2000: 99). In its decision, the trial court noted that in California only one woman can be considered a child's 'natural' mother (*Johnson v.*

Calvert, 1993: 781 see also Schwartz, 1994: 244). The trial court ruled that Mark and Crispina Calvert were the child's genetic parents, and thus, his 'natural' parents and awarded baby Christopher to them. In the appeal, Anna argued that she was the 'natural' mother of the child because she gestated and gave birth to the child while Crispina reiterated that her genetic connection with the child made her his 'natural' mother (*Johnson v. Calvert,* 1993: 779). The appeal court ruled that both claims to motherhood are legitimate in California law and thus relied on the intentions of both parties as expressed in the surrogacy agreement to decide who the mother was. The court reasoned that because the Calvert's intention was not "to donate a zygote to Anna" but rather to have and raise a child of their own, the Calverts were the child's legal parents (*Johnson v. Calvert,* 1993: 782; see also Hammons, 2008: 274). While, "...the court maintained that the genetic tie is stronger than any gestational one, as it was the genetic mother who initiated the surrogacy arrangement because of her desire to have a child" the "...intent was sufficient to merit maternity" (Hammons, 2008: 275). Thus the intention to mother, a more social conception of motherhood, played an important role in the appeal in which the original decision was upheld (*Johnson v. Calvert,* 1993: 787). Overall in gestational surrogacy cases, Hammons argues that the intended mother, rather than the gestational mother, is most likely to be deemed the legal mother including when the commissioning mother is not genetically related to resulting child (2008: 274, 276,277).

In the Johnson case, race also played a role. Both potential mothers were non-white. While Anna Johnson is an African-American woman, Crispina Calvert is Filipino. Despite the fact that the genetically related mother is Filipino, Ikemoto argues that she

was "implicitly made white" as she was married to a white man (1996: 1024). In this case, the experience of pregnancy, while often considered as a major component in defining the experience of motherhood, was belittled (Ikemoto, 1996: 1025 see also Schwartz, 1994: 240) and the genetic link was understood as the stronger defining link to motherhood (Ikemoto, 1996: 1025). The races of the parties involved, "...made the logic of the preference for genetic link obvious" (Ikemoto, 1996: 1024, 1025). According to Ikemoto, "[h]ere, a decision to recognize Ms. Johnson as the child's legal mother would have given a black woman claim to a white child, made the child nominally black, and would have established a white man's paternity to that child" (1996: 1025). This shows that constructions of motherhood have to reflect not only ideals about which women are 'good' mothers, but also, what types of connections among people of different races are legitimate.

Thus the development of procreative technologies has worked to deconstruct the traditional understanding of motherhood. As has been presented in *Johnson v. Calvert* case, in gestational surrogacy, parental relationships are fragmented into the genetic, gestational and social components which has created,"... unprecedented relationships among people bound together by contractual obligation rather than by the bonds of kinship and caring" (*Johnson v. Calvert,* 1993: 793, also see Ragoné, 2000: 61). Presumptions surrounding motherhood, while often naturalized, are in fact the result of ideology largely based on our patriarchical beliefs. Our understanding of motherhood as an important social role is such a strong ideological belief that technologies have been developed not only in order to ensure the safe arrival of babies, but also to enable the

conception of children (through various means) to those who, without technological assistance, would be unable to produce biologically related children. The development of this 'industry' suggests that the ideals of genetic motherhood are internalized to the point where women from Western countries are willing to go overseas in order to achieve their goal of genetic motherhood.

Infertility

Key to the construction of infertility is the expectation that women will and should be mothers in Western society (Miall, 1986: 268). It is the underlying belief and expectation that women are only really women if they are mothers which problematizes infertility. Infertility occurs when a couple cannot "produce a viable embryo" (Spar, 2006: 14) and are unable to conceive after one year of sexual intercourse without the use of contraception (Van Den Akker, 2002: 22) and when, "neither partner is surgically sterile" (Scritchfield, 1995: 132; 132 see also Spar, 2006: 14, Ikemoto, 1996: 1027). Primary infertility occurs when one has never been able to conceive (Van Den Akker, 2002: 23; see also Miall, 1986: 268) and is, according to the World Health Organization (WHO), "...the lack of conception despite cohabitation and exposure to pregnancy within a two year period" (WHO in Widge, undated(b): 67). Secondary infertility and subfertility are terms used to describe the inability to conceive at present, but indicate a previous ability to conceive (Widge, undated(b): 67; see also Van Den Akker, 2002: 22; Miall, 1986: 269). The previous ability to conceive, however, may not have resulted in a live birth (Van Den Akker, 2002: 23). Since infertility has a "time bound" definition, couples who may not actually be infertile are being defined as infertile (Scritchfield,

1995: 132; see also Rothman, 2000:159). Sterility, in contrast, refers to those who are unable to conceive at all (Van Den Akker, 2002: 22) and is a label given to those who cannot be 'medically fixed' (Ikemoto, 1996: 1033). The assumption of fertility has become naturalized (Franklin, 1997: 133-134). Thus, like infertility and perhaps even more so, sterility is also understood as being abnormal or unnatural (Ikemoto, 1996: 1033).

While it is difficult to estimate the extent of infertility, it is currently suggested that it affects approximately fifteen percent of females and between ten and fifteen percent of males (Spar, 2006: 1). According to studies that have been conducted by the World Health Organization primary infertility affects three percent of the population while secondary infertility affects approximately eight percent (Widge, undated(b): 67). Some argue that the problem of infertility is on the rise (Van Den Akker, 2002: 22). However, evidence supporting this argument is lacking, leading most experts to believe that there is no current infertility epidemic (Markens, 2007: 14; see also Scritchfield, 1995: 134). Rather, evidence suggests that infertility rates have been relatively stable, for instance, in the United States for the last fifty or so years (Markens, 2007: 14). Spar notes that the infertility rate of mid-century America is comparable to nineteenth century America or the infertility rate of ancient Greece and medieval Europe (2006: 23).

Understanding infertility and infertility rates have come to be important in North American society. In the past, infertility was mainly a personal concern, however, it has increasingly been constructed as a public, social and medical problem (Butler, 2003: 2; see also Van Den Akker, 2002: 27; Scritchfield, 1995: 131; Rothman, 2000:159).

Accordingly, infertility is generally constructed as an epidemic, a major problem and a negative experience which holds a "negative social stigma" with serious associated consequences (Scritchfield, 1995: 131; see also Beckman & Harvey, 2005: 7, Pfeffer, 1987: 83, Butler, 2003: 1, Miall, 1986: 268). Infertility is a problem for both males and females (Widge, undated(b): 67), however, infertility is often constructed as a woman's problem and women tend to seek out treatment before men (Van Den Akker, 2002: 23). Women also tend to be 'given' most of the blame and the 'fixes' for their infertility (Beckman & Harvey, 2005: 7 see also Scritchfield, 1995: 141, Ikemoto, 1996: 1037). It is also the woman who does not become pregnant as a result of infertility, regardless of who is infertile (the man or the woman) (Ikemoto, 1996: 1037). This works to normalize the idea that it is generally women who are infertile (Ikemoto, 1996: 1037).

Since infertility is most often understood in negative terms, the positive aspects of childlessness are often not acknowledged (Miall, 1986: 271). When they are, those citing them are often considered to be selfish (Pfeffer, 1987: 83). American society is pronatalist. This means that individuals who choose not to have children are forced into defending themselves (Markens, 2007: 3). Once one finds oneself categorized as "involuntarily childless" it becomes one's identifying mark and all other marks are dismissed (Pfeffer, 1987: 82). The condition of infertility is, "...socially constructed and socially legitimated" (Rothman, 2000: 179). For instance, in Ontario, recent newspaper reports have announced that the government has appointed "an expert panel" with goals of advising the government as to what can be done to make infertility treatments and adoption more affordable and easier to use for those, "...Ontarians dealing with the

agony of wanting to have a child and being unable to do so..." (Gillespie, 2008: A1). Certainly, women may find infertility a challenging and even devastating experience. However, the unidimensional construction of infertile women as experiencing personal tragedy and desperate to have a child, often combined with the cultural imperative for women to have children, creates a stigma. Hence, the infertile are unidimensionally characterized as experiencing a personal tragedy (Pfeffer, 1987: 82; see also Butler, 2003) and as being desperate to have children.

The importance Western culture places on fertility and bearing children has contributed to a construction of infertility as deeply problematic for women. The negative impact on the infertile is related to Western pronatalist views on marriage (Miall, 1986: 270). Fertility is closely tied to womanhood. Women are generally considered responsible for their infertility (Spar, 2006: 7) and it is not unusual for women to blame themselves for their infertility and to regard it as a personal failure (Franklin, 1997: 137). Women without children often have a sense of worthlessness or are expected to feel that way because of the importance placed on this role (Pfeffer, 1987: 81-85). Infertility is understood as a "wretched curse" and constructed as a disease (Spar, 2006: 2 see also Doyal, 1987: 182) or disability (Rothman, 2000: 95-96; see also Miall, 1986: 269). Such an understanding of infertility has ultimately led to viewing women without children with pity (Spar, 2006: 6). While it is not actually a life threatening disease, it creates an emotional reaction that is similar to one's reaction to a major illness (Spar, 2006: 2, 16). Studies have shown that women who "suffer" from infertility tend to show higher levels of other medicalized illnesses such as depression and heart disease (Spar,

2006: 16). For women, the "condition of infertility" can threaten identity and can create feelings of inadequacy and guilt (Franklin, 1997: 137; see also Van Den Akker, 2002: 35). Infertility can also produce feelings of "unnaturalness" and sexual and reproductive uselessness (Franklin, 1997: 137; see also Van Den Akker, 2002: 35). Some women have been noted as feeling unfulfilled in their marriage due to their inability to reproduce (Franklin, 1997: 133). Today, children continue to be understood as completing a marriage, thus for a woman to complete her role in her marriage she must become a mother (Franklin, 1997: 139). Being unable to conceive and thereby become a mother defines women's bodies as obstacles preventing them from fulfilling their role in their marriage, which in turn prevents them from achieving 'normal' female adulthood (Franklin, 1997: 138).

Often times this 'curse' of infertility becomes all consuming and leads sufferers to do whatever possible to produce a genetically related child. Western culture emphasizes the ideal that children are 'priceless', thus explaining the willingness of many to spend large sums of money in order to obtain a 'child of their own' (Spar, 2006: 2). However, this desperation may in fact not be caused by actual infertility (Pfeffer, 1987: 83). It is the construction of infertility that has led to extremes in order to obtain a child. Pfeffer argues that,

> [d]esperation combined with infertility appears to produce a particularly potent mix; one that forces fecund women to lease their womb [sic], sends infertile men and women scouring the world for orphans to adopt

> and incites some doctors into developing new techniques that subject people to many indignities (1987: 82).

Some of the concerns regarding infertility can be understood as developing out of professionals' interest in providing medical services to 'fix' infertility (Pfeffer, 1987: 84; see also Stanworth, 1987: 13). The construction of infertility as a medical problem which is often fixable has worked to promote technological medical treatments as the solution to the problem of infertility, while ignoring its prevention (Scritchfield, 1995: 132 see also Doyal, 1987: 189). The increasing availability of treatment (Spar, 2006: 23) and the social redefinition of the 'problem' of infertility (Scritchfield, 1995: 131,134) have led to the perception that infertility is on the rise. Increasing media attention focusing on infertility and biomedical technologies as the solution to infertility have also contributed to the social construction of an "infertility epidemic" (Markens, 2007: 15). Thus, since a 'real' increase in fertility rates has not been proven, it can be argued that it is rather the social attention given to infertility that has made infertility appear as a major problem worthy of concern (Markens, 2007: 15).

Despite the fact that no increase in infertility rates has been proven, the number of available medical infertility treatments has increased. Both the number and type of providers offering fertility solutions have increased since the early post war period (Spar, 2006: 23). However, such medicalized 'fixes' are not equally available to all infertile individuals. Patriarchy is a deeply held value in Western society and this belief runs through out political, social, economic and class systems (Millett, 1970: 25). Those who are understood as being on the "right side of the line" are those who are white, middle

class, married and heterosexual (Ikemoto, 1996: 1038, 1042). This means that those defined as being on the 'wrong' side of the line are those who are non white, low income, non-married and homosexual (Ikemoto, 1996: 1038, 1042). Hence, those individuals on the 'right' side are constructed as more deserving of infertility treatments than those on the 'wrong side'.

Available options for couples who are deemed to be infertile are shaped by social factors such as marital status, education, age, class, gender and race (Pfeffer, 1987: 83) as well as sexual orientation. The definition of infertility assumes heterosexuality and marriage:

> [w]hen we read heterosexuality into the definition of infertility, it becomes impossible for a non-partnered person or lesbian couple to be included among the infertile. Since procreative technology use is primarily understood as infertility treatment, access to technology usually hinges on the diagnostic power of the definition (Ikemoto, 1996: 1027).

Thus, the naturalized desire to become a parent has been reserved for heterosexual, married couples. Our society denaturalizes the notion of parenthood in relation to homosexual and unmarried couples and thus "the biological maternal instinct" is assumed not to affect those with these characteristics (Doyal, 1987: 181-182). According to Ikemoto, "[p]rocreation and parenthood are so strongly associated with heterosexuality and marriage that procreation and lesbians and parenthood and gay men seem disassociated" (1996: 1053). While in some small way (by virtue of her being a female capable of bearing children), we can picture a lesbian woman as being pregnant and

having a child (thereby becoming a mother) it is much more difficult for our society to imagine gay men as having children (Ikemoto, 1996: 1054). This is because, "...social fatherhood depends on motherhood" (Ikemoto, 1996: 1055). Thus socially, one can only be a father to a child through a recognizable connection to the child's mother.

Often medical clinics that screen[6] individuals for infertility treatments use such social criteria which ultimately reinforces, "...the conflation of marriage, heterosexuality, and procreation" (Ikemoto, 1996: 1029 see also Doyal, 1987: 182). Ikemoto (1996) has observed this exclusion in the West. While not all clinics restrict access based on particular social criteria, fertility clinics such as the Akanksha Infertility Clinic in Anand, India which is largely run by Dr. Nayna Patel, restrict access to gestational surrogacy arrangements to heterosexual couples. Patel reasons that she simply does not, "...feel right about helping them [homosexuals]" (Haworth, 2008: 3). It is Dr. Patel's personal beliefs and prejudice coupled with her powerful position not only as an IVF specialist but also as the medical director of the Akanksha clinic (http://www.ivfcharotar.com/our_team.html) which influences who has access to infertility treatments. Thus for her, and likely for many others, using assisted reproductive technologies only for heterosexual and married couples as a means to achieve parenthood goes unquestioned and is understood as natural (Ikemoto, 1996: 1029).

[6] Screening occurs in part through medical definitions of words such as infertility which presume heterosexuality. Infertility can only be medically achieved if conception has not occurred through male/female vaginal sexual intercourse. Thus, it is impossible, by this assumption in the definition, for a homosexual couple to conceive and so they do not qualify as infertile (Ikemoto, 1996: 1027). Those who cannot afford the treatments are also denied access (Ikemoto, 1996: 1030). Furthermore, clinics often use marital status, age and sexual orientation "...to exclude unmarried persons, especially lesbians and gay men, from procreative technology use" (Ikemoto, 1996: 1028).

There is a racial and classist bias in infertility concerns. Fertility discourses work to promote fertility as a "desirable condition" differently to women depending upon their racial identification and social class (Lowry, 2004: 361). In the infertility discourses, "...lack of economic privilege or professional status signals race" (Ikemoto, 1996: 1050) and the dominant discourse surrounding fertility concerns heterosexual couples and homosexual couples have become nearly invisible (Ikemoto, 1996: 1053). Fertility treatments, such as IVF and surrogacy, are expensive. Anyone who wants to obtain such treatment must be able to incur the financial expense (Ikemoto, 1996: 1030). The inability to pay for treatment acts as a barrier to ARTs and thus keeps out lower income couples (Ikemoto, 1996: 1030). In particular, most of those who are "surrogacy users" can be described as upper-middle class, educated, professional, approaching mid-life and white (Ikemoto, 1996: 1030). It tends to be white, heterosexual couples from the upper-middle class who are not only the ones who are more likely to have access to and be able to afford treatment, but are also the ones most likely to be encouraged to do so (Scritchfield, 1995: 138). With respect to the use of Indian gestational surrogate mothers by those from more developed countries, this pattern can also be observed. It is important to note that in North America, there has been growth of unmarried heterosexual as well as gay male use of gestational surrogacy. However, generally fertility discourses work to maintain a social status quo which enables white, heterosexual, well off individuals to have access to fertility treatments not only locally but also globally.

Reproductive and Assisted Reproductive Technologies

The importance placed on the role of motherhood and the undesirability of infertility has led to increasing use and development of technologies which help to assist reproduction and conception. Reproductive technologies can be understood as, "...those technologies concerned with human fertility, gestation, and birth: contraceptive technologies, ARTs, and fetal monitoring technologies" (Lowry, 2004: 360). An assisted reproductive technology is, "...any treatment or procedure that involves the *in vitro* handling of human oocytes and sperm or embryos for the purposes of establishing a pregnancy" (Butler, 2003: 3). Both reproductive technologies and ARTs involve the medicalization and manipulation of female bodies. In vitro fertilization, for instance, requires invasive medical techniques. IVF occurs when the fertilization of an ovum takes place, "outside the human body in a laboratory" (*Johnson v. Calvert,* 1993: 790; see also Van Den Akker, 2002: 62). The IVF procedure includes the collection of both the eggs from a woman's ovaries and the man's sperm. Both are 'mixed' together in a Petri dish, with the hopes of fertilization taking place (Van Den Akker, 2002: 62; see also *Johnson v. Calvert,* 1993: 790). Upon fertilization, the fertilized egg(s) are, "...left to culture for about a day to ensure normal development" (Van Den Akker, 2002: 62). If this is successful, the embryos are then inserted into the woman's uterus (Van Den Akker, 2002: 62). Generally up to three embryos are transferred, often leaving the remaining embryos to be frozen (Van Den Akker, 2002: 62). IVF is likely the most used fertility treatment world wide (Van Den Akker, 2002: 63) and is said to have a 25% conception

success rate with a 15% "take-home-baby rate" per treatment cycle (Van Den Akker, 2002: 63).

The "naturalness of pregnancy and childbirth" has been changed into an "illness" or "unnatural condition" (Woliver 2002: 30; see also Woliver, 1996: 353). The normalization of technological intervention in pregnancy and birth opens the door to an increased use of intense interventions such as new reproductive technologies prior to pregnancy. ARTs receive much press attention, and have an aspect of the miraculous about them. They are often invasive and pose medical risks for those using them. However, their social acceptability builds on a wide range of less attention-grabbing reproductive technologies,[7] which are increasingly mediating pregnancy and childbirth and drastically changing women's experiences of childbirth and motherhood. Such technologies were once used only in "special cases", however, many of them, like the ultrasound and fetal monitors, have come to be used on most women (Woliver, 2002: 29; see also Woliver, 1996: 353). The growing use of these technologies 'normalizes' them, while reinforcing the belief that the new technologies have been created for the benefit of women and have been created in response to women's demands (Woliver, 1996: 352; see also Stanworth, 1987: 12; Woliver 2002: 29).

The normalization of such medical technologies, however, is questioned by some. Some argue that the increasing medicalization of pregnancy takes power and voice away from women and has come to privilege specialist knowledge (Shiva, 1993: 23) and that ARTs may also lessen women's control and power over their own bodies (Woliver,

[7] i.e. caesarian sections, episiotomies, labour inducing technologies (Stanworth, 1987: 11).

1996: 347; see also Woliver, 2002: 27). Some pro-life groups are against the use of reproductive technologies as they understand them to be tampering with nature (MacDonald, 1994: 86 see also Doyal, 1987: 174) and many feminists argue that these technologies are another example of patriarchical control over reproduction (MacDonald, 1994: 86 see also Doyal, 1987: 174) and further intensify power relations over the female body (Balsamo, 1996: 82). According to Woliver ARTs are changing women's lives as reproductive processes, such as conception, gestation and birth, are predominantly under medical control which tends to pathologize reproduction (1996: 346). Such power relations have become institutionalized through the creation of medical centers that focus on providing various reproductive services as well as "...through the establishment of reconstructed legal rights and responsibilities of parents, donors, fetuses, and resulting children" (Balsamo, 1996: 82).

While all technologies and knowledge are indeed formed out of both political and patriarchical ideologies, they cannot be said to affect all women in the same manner (Balsamo 1996: 96). Thus others suggest that reproductive technologies are in fact beneficial for women as they can offer hope to those infertile individuals who want a genetically related child (Balsamo 1996: 96; see also Woliver, 2002: 27; Gupta, 2006: 28). ARTs have been socially constructed as and are promoted as treatment for infertility and so those who are infertile use them in hopes of genetic reproduction (MacDonald, 1994: 86; see also Ikemoto, 1996: 1021). It is argued that ARTs give infertile individuals a chance to procreate, a chance they would not have without such technologies. Some also understand these technologies as allowing infertile couples a chance at fulfillment

and responsibility (*Johnson v. Calvert,* 1993: 791; see also Van Den Akker, 2002: 27). Thus, one's quality of life, it has been argued, can be enhanced by having a child through the use of infertility treatments (Van Den Akker, 2002: 137). Infertility treatments, then, can be understood as empowering for infertile individuals (Franklin, 1997: 143-144). This empowerment, however, occurs within the context of ideological beliefs surrounding motherhood. However, it is important to note that this is not the only way to understand the social role of ARTs. Some of the more negative conceptions of the use of infertility treatments, including arguments that they are generally immoral, exploitive and commodify the human body, will be discussed in the following chapters.

Highly technical infertility treatments, such as IVF and its derivatives, are increasingly relied upon as they are presumed to be more effective than low technological fertility treatments, (Ikemoto, 1996: 1034). Low tech methods are procedures such as assisted donor insemination, which involves the direct insertion of the semen into the vagina (Van Balen and Inhorn, 2002: 13). The focus of attention on high tech treatments has meant that these treatments are in greater demand, and may further the idea that the low tech methods are not as efficient (Ikemoto, 1996: 1034-1035). According to Van Den Akker, "[i]nfertility is [now] dealt with by increased demand for better and more sophisticated treatment, services and economic factors, and more teaching for professionals and practitioners" (2002: 27).

Since highly specialized ARTs require invasive medical intervention by highly trained doctors, ARTs separate sexual intercourse from reproduction (Butler, 2003: 5) and this is what makes them so challenging. ARTs have separated the uterus from the

female body and thus have reduced reproduction into "discrete stages" which include, "...egg production, fertilization, implantation, feeding, and birthing" (Balsamo, 1996: 91-92). Furthermore, the use of procreative technologies, "...segregates and devalues the significance of pregnancy and birth from the genetic link" (Ikemoto, 1996: 1041). The use of "biotechniques" in new reproductive technologies has isolated and intervened in the normal reproductive processes which occur in the female body and this has enabled the objectification and fragmentation of the female body (Balsamo, 1996: 91-92 see also Oakley, 1987: 38). Procreative technologies have blurred the line between technology and the human body (Ikemoto, 1996: 1013) and have separated the biological function from the social function. Because ARTs have come to manage the body so greatly (Balsamo, 1996: 91), it has caused some to understand birth in itself as an industry in which fertility clinics have become "commercial babymaking services" (Balsamo, 1996: 91).

The language surrounding new reproductive technologies upholds divisions between medical and scientific professionals and couples seeking assistance with infertility. The term 'surrogate mother' devalues the importance of pregnancy as an "act of mothering" (Stanworth, 1987: 20) and with respect to gestational surrogacy, surrogate mothers are termed as "carriers" and "womb donors" thus emphasizing "...their instrumentality in reproduction" (Goslinga-Roy, 2000: 121). The couples who seek gestational surrogacy are referred to as the commissioning parents or couple, the "intended" and as the "recipient" couples and are considered the genetic and therefore

"real" parents (Goslinga-Roy, 2000: 121). As in the *Johnson v. Calvert* case, these terminologies erase the work done by the gestational surrogate mother.

Infertility has been constructed as major social and medical problem and has come to be internalized as an undesirable condition, particularly for women. This negative construction of infertility for women has developed out a patriarchical belief system and the notion of motherhood. Motherhood is understood as highly desirable quality in women and particular importance is placed on the genetic connection. Since this connection is deemed to be so important, those who have come to understand themselves as having difficultly conceiving a child 'naturally' in many cases have turned to reproductive and ARTs. The importance placed on motherhood/parenthood and biological children has in turn worked to legitimize the use of technology. The socially constructed undesirability of infertility and ideals of motherhood/parenthood have undoubtedly been a major factor in the development of new reproductive technologies and ARTs. The quest for conception has also enabled and encouraged individuals to go to extremes in order to achieve the status of biological parenthood. One of these extremes can be understood as the use of Indian gestational surrogate mothers by individuals from more developed countries.

Globalization, Markets and Reproductive Tourism

Globalization

Indian gestational surrogacy tourism has in part developed as a result of our increasingly globalized world. Globalization can be understood as, "…'a social process in which the constraints of geography on social and cultural arrangements recede and in

which people are becoming increasingly aware that they are receding' "(Waters as cited in Scott and Marshall, 2005: 249). Furthermore, globalization is, "...the worldwide diffusion of practices, expansion of relations across continents, organization of social life on a global scale, and growth of a shared global consciousness" (Lechner as cited in George Ritzer, ed. *Encyclopedia of social Theory* in Ritzer, 2004: 160). Theories of globalization study emerging globalized cultural systems and propose that various social and cultural developments have created a global culture (Scott and Marshall, 2005: 249). Such developments are many and include things such as a worldwide system of information, "the emergence of global patterns of consumption and consumerism", "the spread of world tourism" and "the decline of the sovereignty of the nation-state...."(Scott and Marshall, 2005: 249). From a globalization perspective, the world is understood as one single place (Scott and Marshall, 2005: 249). The process of globalization continues to expand and is a process which has clearly had a great effect the world over (Ritzer, 2004: 160).

In our globalized world, manufactured goods are produced everywhere (often in poorer, less developed nations) for global consumers (Dossani, 2005: 241). It has become increasingly popular for developed nations to outsource various products and services to less developed countries in order to increase companies' profits. A recent trend in globalization and international trade has focused on services such as payroll services, call centers, telemedicine, IT services, labour migration and tourism (Dossani, 2005: 241-242). Various services have come to play an important role in international trade for lesser developed and more developed countries (Dossani, 2005: 242) and can be

understood as a key factor in its growth (Dossani, 2005: 242). The IT services industry is particularly well known to be outsourced to countries such as India. India, in particular, has come to be a leader of outsourced services (Dossani, 2005: 242) and this has been one way that it has become more highly integrated into the global economy (Pedersen, 2008: 118, 123). Knowledge based industries, such as the software industry and the pharmaceutical industry, are also growing in India (Pedersen, 2008: 102) with recent estimates suggesting that the IT economy, including telecommunications and 'infotainment', accounts for approximately 3.7 per cent of India's GDP in 2000-2001 (Pedersen, 2008: 102). A major reason why foreign companies began outsourcing to less developed nations such as India was in order to benefit from lower labor costs. However, once they began outsourcing, they also learned that the labour was also highly skilled (Segal, 2008: 424).

However, it is no longer merely IT services that have been criticized for being outsourced to less developed countries. Arguably one of the newest uses for some third world nations is health care. It has become common for individuals from comparatively wealthy nations to travel to less developed nations in order to acquire various health services. For instance, health tourism is being promoted by the Indian government (Stephenson, 2009: 189) and according to a bulletin published by the World Health Organization, health tourism in India can be understood as an example of how India has come to profit from both outsourcing and globalization (Stephenson, 2009: 189). For instance, India's Ministry of Tourism advertises various medical services including

cardiac surgery, oncology services, orthopedics and joint replacement as well as holistic health care services (Chinai and Goswami, 2007).

Within the realm of health tourism is reproductive tourism. ARTs, and specifically gestational surrogacy, have become a recent addition to globalized health services (Deech, 2003: 425). According to one reporter, Manish Mehta, "[a]fter IT services it seems it's now the turn of babies to be outsourced from India" (Stephenson, 2009: 192). The popularity of gestational surrogacy outsourcing to India appears to be on the rise with one website identifying up to seventy five doctors and clinics throughout India that offer international surrogacy (Stephenson, 2009: 192). This growing internationally based surrogacy industry suggests that in economic terms, Indian hospitals and gestational surrogates have come to provide consumer cost advantage over their American competitors (Stephenson, 2009: 194).

The advances made in reproductive medicine have created a baby market (Spar, 2006: xi). The new technologies have made it increasingly easy for potential parents to pick and choose their desired components of assisted conception and now they can also choose which governing jurisdiction they would prefer (Spar, 2006: 86). Potential commissioning parents have found more sympathetic courts across state boundaries when legislation in their own jurisdiction is unfavourable (Spar, 2006: 71). It important to note, however, that international surrogacy cases have also included instances of people from developed nations traveling to other developed nations. Such cases are often the result of legislative restrictions in one's own country (Spar, 2006: 85). Thus assisted reproductive services and gestational surrogacy services are no longer only available in

one's own back yard. If the *price is not right*, or the legislation is not favourable, individuals and couples can depart for a more favourable destination in order to obtain their desired procedure at the desired price. Hence some argue that the development of an international trade was the logical next step in gestational surrogacy (Spar, 2006: 86).

Currently, international surrogacy has not been legislated (Stephenson, 2009: 190). Furthermore, "[i]nternational surrogacy compounds the soci-economic class issues by injecting concerns about *global* inequality and exploitation" (Stephenson, 2009: 191). Arguably, gestational surrogacy will become increasingly globalized, for "[i]f there is demand in one part of the world (and there is) and lower-priced supply in another (and there is), then the record of both trade in general and reproduction in particular suggests that commerce will proceed" (Spar, 2006: 88).

Tourism

Like sex tourism, the issue of individuals from the West and other parts of the world traveling for the purposes of engaging in sexual behaviours for payment (see Downe 2006), health tourism is another form of tourism that has emerged out of globalization (Blyth and Farrand, 2005: 93). At one end of the spectrum is abortion tourism, which can be understood as individuals traveling in order to have access to safe abortion care outside of the area in which they live (Bloom, 2008). Uneven abortion services across the United States have contributed to internal abortion tourism, with approximately 25% of American women required to travel 50 miles and more in order to obtain abortion (Bloom, 2008). While abortion was legalized in Canada in 1988, Sethna argues that in Canada all women do not have equal access to abortion due to geographic

distance and other barriers such as anti-abortion groups which intimidate women (Sethna, 2007: 640,642). In Canada, the provinces control public health care and thus services vary in each province. For instance, the province of British Columbia has 26 hospitals and 3 private clinics which provide abortion services and Ontario has 33 hospitals (with only one of these being in Northern Ontario) and 8 private clinics (7 in Toronto, and 1 in Ottawa) (Sethna, 2007: 643). Other provinces, however, have fewer options for abortion services (Sethna, 2007: 643). Women in places such as Newfoundland have to drive for up to 12 hours in order to get to the province's only clinic located in St. Johns (Sethna, 2007: 642) and Prince Edward Island provides *no access,* private or public to abortion (Sethna, 2007: 643). The uneven access to abortion may also be a result of the decline in abortion providers and the decline in available abortion services provided by some public hospitals (Sethna, 2007: 642).

These "abortion journeys" have developed as a means to deal with both the cost of abortion services and "restrictive legislation" in one's own country (Bloom, 2008). Countries such as Ireland and, until recently, Mexico, do not provide legal access to abortion (unless under circumstances deemed to be life threatening to the mother), thereby pushing women (at least those who could afford it) to travel outside of their countries in order to have access to safe abortions (Bloom, 2008). The Irish Family Planning Association and the Safe and Legal Abortion Rights Campaign in Ireland report that there are approximately two-hundred women who travel each week to the United Kingdom from Ireland in order to obtain safe abortions (Bloom, 2008), and at least 1,000,000 Irish women are reported to have traveled to England for safe abortions over

the last 20 years (Bloom, 2008). Reports also show abortion tourist destinations as including Barcelona, Spain, Sweden, Japan and Puerto Rico (Bloom, 2008).

Thus, abortion tourism not only occurs within national borders, but on an international scale as well. Legal restrictions as well as socio-economic status are the major factors contributing to abortion tourism (Bloom, 2008). It is only those with the financial means who are able to flee restrictive laws in their home countries in order to have access to safe abortions (Bloom, 2008). Thus it becomes, "disproportionately women or girls who are young and/or poor, indigenous, of color, an immigrant, a refugee, and/or geographically isolated" who suffer the most in facing the lack of access of abortion (Bloom, 2008).

At the other end of the spectrum, reproductive tourism has also developed out of globalization and health tourism (Blyth and Farrand, 2005: 96) and can be understood as, "...the movement of citizens to another state or jurisdiction to obtain specific types of medical assistance in reproduction that they cannot receive at home" (Pennings, 2004: 2690), or that they cannot afford at home. Countries differ in what is available in terms of assisted reproductive technology and both knowledge and people have become increasingly mobile (Deech, 2003: 425). This creates an atmosphere which allows those with the means and opportunities to travel abroad in order to have access to the procedures of their choice (Blyth and Farrand, 2005: 93). In a global village with its accompanying available transportation and communication, individuals are capable of traveling and engaging in reproductive tourism "...in order to exercise their personal reproductive choices in other less restrictive states" (Blyth and Farrand, 2005: 92).

Many factors have been identified that lead to reproductive tourism. Some individuals consider reproductive tourism as some services are not available in their home country due to lack of medical technology and expertise (Pennings, 2004: 2690; see also Blyth and Farrand, 2005: 96-98), or because the waiting lists they face at home are too long (Pennings, 2004: 2690). Often potential patients possess characteristics through which they are deemed 'unfit' to be parents (Pennings, 2004: 2690). Such people include postmenopausal women (Pennings, 2004: 2690), homosexuals (Pennings, 2004: 2690; see also Blyth and Farrand, 2005: 96-98; Spar, 2005: 300) or unmarried individuals (Blyth and Farrand, 2005: 96-98).

Another reason for the development of reproductive tourism has been the legal prohibitions placed on particular reproductive services in certain countries (Blyth and Farrand, 2005: 96-98; see also Spar, 2005: 299) for example, Canada's ban on commercial surrogacy. These prohibitions are often based on moral or ethical grounds (Pennings, 2004: 2690) or are based on the idea that certain techniques are "medically unsafe" (Pennings, 2004: 2690; see also Blyth and Farrand, 2005: 96-98). Additionally, the legal red tape surrounding gestational surrogacy, in terms of parenthood, in countries such as the United States (as noted, *Johnson vs. Calvert*), has led to individuals traveling to countries with fewer legal parenthood restrictions.

Yet another reason for the development of reproductive tourism is a practical one, cost. Blyth and Farrand explain that generally, ARTs have become commercialized. While many reproductive tourists are wealthy in comparison to most, the price tag in ones own country may be considered excessive (Pennings, 2004: 2690) and so some

reproductive tourism can be considered "international bargain hunting" as assisted reproductive services can be less expensive in some countries. For example in Belgium, it has been found that the significantly lower cost of ART procedures has led to an increasing number of foreigners using assisted reproductive services in Belgium. In 1999 30% of IVF and 60% of donor egg recipients in Belgium were foreigners (Blyth and Farrand, 2005: 99 - 102).

Another example is found at the Barbados Fertility Center (http://www.barbadosivf.org) which promotes itself through "IVF Holidays". Couples are encouraged to travel to Barbados for a 'holiday' while receiving their fertility treatment. Here, the services particularly focus on IVF treatment for the traveling women themselves and do not work with gestational surrogate mothers. The Barbados Fertility Center refers to this as a "Holiday with Purpose" and notes that, "[i]n between your appointments, you have constant access to our team of experts by cellular phone but with the freedom of being on holiday" (Barbados Fertility Center, 2008). Multiple holiday packages are available, including the Comfort package ($5,000US), the Luxury package ($6,500US), the Premium package ($10,000US) and finally the Elite package ($30,000US) with the prices varying according to treatments and accommodation (Barbados Fertility Center, 2008: personal correspondence).

This can also be seen in the case of India, where gestational surrogacy costs are significantly less than in Western countries such as the United States. While there are national as well as international statements that oppose the commercialization of ARTs, many such services operate on a market basis, which has developed because of the

relatively low priority of such services in public health (Blyth and Farrand, 2005: 99). In the United States, the total cost of gestational surrogacy can be up to $80,000 US (Warner, 2008: 1), with estimates suggesting surrogacy compensation fees beginning at $18,000 with more experienced surrogates earning more[8]. In India, the cost is a mere fraction of the American prices with a total cost of around $12,000 including medical fees and the surrogate's compensation (Haworth, 2008: 1). Indian gestational surrogate mothers earn between $6, 000 - $10,000US. This represents the equivalent of ten to fifteen years of regular income in India (Warner, 2008: 1). Thus it is argued that, "...market laws of supply-and-demand are clearly evident..." (Blyth and Farrand, 2005: 99).

Thus out of the development of globalized ARTs has come reproductive tourism in which couples scour the globe in order to obtain treatment for their infertility at economical prices. It seems Field (1988) anticipated such reproductive tourism in her comment, "[a]s interest in surrogacy grows and the surrogacy business develops, many may turn to Third World women to perform for a much smaller fee" (32). Reproductive tourism is often criticized for being discriminatory as it is accessible only to those who are relatively financially well off (Pennings, 2004: 2191). While some argue that "reproductive tourists" are generally wealthy people and so reproductive tourism is likely to be pursued by a minority of people (Blyth and Farrand, 2005: 102), others believe that cost driven reproductive tourism will only increase. Since cost is a motivational factor, Pennings believes that if the financial costs of ARTs were covered by public health

[8] www.surrogenesisusa.com/.

insurance, reproductive tourism could be prevented. While reproductive tourism is typically understood as problematic, Pennings suggests that reproductive tourism can "reduce social injustice" as it would allow less wealthy patients to obtain the services they want that they cannot afford in their own countries (2004: 2691).

The Politics of Gestational Surrogacy

There is some commonality in the issues surrounding gestational surrogacy whether it occurs inside or across national borders. However, these issues manifest themselves differently in diverse social contexts. Thus, there is a need to be aware of the effects of globalization and how these globalized effects are both similar to and different from issues surrounding gestational surrogacy within nations. In a globalized world, it seems that almost everything and everyone can cross territorial boundaries. Poorer countries are not only used by Westerners as their global 'backyard' for leisure traveling or for producing less expensive products and services, but they have also become health and reproductive tourism hot spots.

Dominant critiques of gestational surrogacy have developed in many more developed countries such as the race and class position of surrogates vis-à-vis commissioning couples, exploitation and commodification of the human body; as well as concerns centering around choice. After a discussion of theses issues, I turn to a discussion of how gestational surrogacy has been dealt with legally in various countries. While legal concerns seem to have initially arisen in more developed countries with respect to ARTs and in particular gestational surrogacy, this new development of cross-

border use of reproductive technologies has raised legal issues internationally. These issues are now concerns at the national and international levels.

Race, Class and Surrogacy

It is important in our understanding of gestational surrogacy, and particularly reproductive tourism as it relates to India, to examine race and class issues. Within the United States, it is not unusual for the commissioning couple and the gestational surrogate to be of different race, ethnic or cultural backgrounds (Ragoné, 2000: 65) and, "[i]n fact, approximately 30 percent of all gestational surrogacy arrangements at the largest program now involve surrogates and couples matched from different racial, ethnic, and cultural backgrounds" (Ragoné, 2000: 65).

It is often socially and economically disadvantaged women who agree to become gestational surrogate mothers, at least in part for financial gain. Eichler found that commissioned surrogate mothers have lower educational levels compared to the commissioning couples (1994: 201). Most of the women who are commissioned as surrogate mothers are either housewives or work in to the pink collar ghetto while their husbands were generally employed in blue collar work (Eichler,1994: 202). In the West, economically-disadvantaged women are often also members of racial minority groups. Poverty among women, and particularly women of colour is on the rise in the United States (Proctor and Dalaker, 2002 as cited in Andersen and Hill Collins, 2004: 75) and approximately one in four African Americans in the United States live below the poverty line in comparison to one in nine white people (Pattillo-McCoy as cited in Andersen and Hill Collins, 2004: 158).

In contrast to the gestational surrogate, the commissioning couple often belong to the professional class and have higher incomes, and so typically have more disposable income (Eichler, 1994: 203-204; Field, 1988: 25). Field notes that the option of paying a surrogate is not available to those who are truly poor (1988: 26). Because surrogates tend to have lower levels of education and are less financially stable than their commissioning couples, this indicates that the commissioning couple belong to a higher social class (Eichler, 1994: 202). Thus, one's economic position is a major factor in their ability to use ARTs such as surrogacy.

The apparent divisions between the socio-economic classes of the gestational surrogate mother and the commissioning couple has led to concerns in the United States and Canada about the development of a "breeder class", consisting of poor women who will be employed to carry children by comparatively wealthy individuals (*Johnson vs. Calvert,* 1993: 792; see also Field, 1988: 30; Markens, 2007: 60; the Canadian *Assisted Human Reproduction Act*).

Western concerns regarding socio-economic division between gestational surrogate mothers and commissioning parents have now become international concerns. India is a poor country compared to most Western nations. It has not been relatively wealthy Indian women who have been agreeing to act as gestational surrogate mothers for wealthier couples from other countries, but rather, those who are relatively poor. The pattern of gestational surrogate mothers belonging to a lower socio-economic position than commissioning couples has reached across oceans to India. It is feared that "breeder women" will not only exist on a national scale but on an international scale, "[t]he same

women who are pushing white babies in strollers, white old folks in wheelchairs, can be carrying white babies in their bellies. Poor, uneducated, third-world women and women of color from the United States and elsewhere, with fewer economic alternatives, can be hired more cheaply" (Rothman as cited in Markens, 2007: 84; see also Spar, 2005: 300-301). Thus it is the, "...'well-heeled people from well-regulated countries [who] go to less well regulated ones to buy services (Rose and Rose, 2003 cited in Pennings, 2004: 2691). The very large difference in financial compensation given to Western and Indian women shows that Indian women are "less expensive" and leads to the possibility of increased exploitation of Indian women by 'tourist' couples. Haworth notes that of the Indian gestational surrogate mothers in the Akanksha Infertility Clinic in Anand, India who have been commissioned by a couple, most are impoverished (2008: 1). This seems to suggest that Western nations are using these women for the same reasons Western nations build factories in Third World countries: because the labour is "cheap" and there are fewer legal considerations (to be discussed) which allow Western nations to exploit these labor markets with greater ease.

Not only are the lower prices of Indian gestational surrogate mothers appealing to commissioning couples, but part of the appeal of gestational surrogacy, compared to genetic-gestational surrogacy, is the separation it can allow between the gestational surrogate mother and the child she carries for another person. Generally, gestational surrogate mothers do not see the children they carry as their own (Ragoné, 2000: 69). Gestational surrogate mothers achieve separation from the fetus based on the idea that the child is not genetically theirs (Ragoné, 2000: 64-65). Real and ethnic differences

between the commissioning couple and the gestational surrogate mother can be conceived as a positive thing to those involved. When the child is of a different racial or ethnic background, social constructions of race and ethnicity in defining core differences between people, allows the distinction between the surrogate and child to become much clearer (Ragoné, 2000: 67). Difference in physical appearances expected through social constructions of racial differences help the separation process between the gestational surrogate and child (Ragoné, 2000: 66). One black surrogate, Carol, says, "[m]y mom is happy the couple is not black because she was worried I would want to keep it [the baby]. The first couple I was going to go with was black. I don't want to raise another kid" (Ragoné, 2000: 66).Thus Ragoné argues that while Carol knows the child she is carrying is not genetically hers, "...certain boundaries become blurred for her when an African American couple is involved, whereas with a Euro-American couple the distinction between genetic/nongenetic or self/other is made more clear" (Ragoné, 2000: 67). Linda, a Mexican-American gestational surrogate mother, carried a child for a Japanese couple. Linda felt that the child was not, nor ever could be hers because the child was genetically Japanese (Ragoné, 2000: 66). Thus according to Ragoné, "...her reasoning illustrated how beliefs concerning racial difference can be used by surrogates (and couples) to resolve any conflicting feelings about the child being related to a surrogate by virtue of having been carried in her body" (Ragoné, 2000: 66).

Consequently, social constructions of racial difference are used to reinforce the idea that the child carried by the gestational surrogate mother is not theirs. North Americans tend to understand blood connections as a determining factor of kinship, and

generally assume that individuals of different races have no blood connection. Hence in North American society, people do not perceive individuals of different races as belonging to the same kinship group or family. This difference may actually facilitate a separation process between the gestational surrogate mother and the child she carries (Ragoné, 2000: 66).

In traditional surrogacy, likeness between the commissioning mother and the surrogate mother is desirable to enable a child that looks like both of the commissioning parents. However, in gestational surrogacy, there is (most often, except when donor gametes are used) a genetic connection to both commissioning parents and so likeness between a gestational surrogate mother and the commissioning mother is no longer necessary (Ragoné, 2000: 68) and in fact may be understood as negative. Commissioning couples then may find it more desirable for the gestational surrogate mother to be of other racial or ethnic background. This difference provides a distance between the commissioning couple and the gestational surrogate mother which enables a separation between the gestational surrogate and the resulting child which is achieved through the gestational surrogates' "...manipulation of existing cultural ideation about racial difference" (Ragoné, 2000: 70). Thus racial or ethnic difference may be a way for gestational surrogates and the commissioning couples to create and reinforce a distancing and maintain boundaries (Ragoné, 2000: 71) and so it is not surprising that people are no longer looking for gestational surrogate mothers who physically resemble the intending mother (Ragoné, 2000: 68).

The combination of class and ethnic or racial differences between commissioning couples and gestating women, thus creates a desirable distance for those involved in gestational surrogacy. In terms of worldwide structures of class this can be observed in the case of Indian women carrying children who are genetically linked not to them but often to white foreigners. The distancing, physical, emotional and geographical, achieved through the use of Indian gestational surrogate mothers by those foreigners may in fact be one of the great appeals to those Caucasian, Japanese or other wise non-Indian women looking to hire a gestational surrogate mother. The physical and racial difference between Caucasian Westerners and the Indian gestational surrogate mothers seems obvious, thus helping to construct the resulting child as belonging to the commissioning couple. The racialized difference helps to maintain the distinction between the child and its gestational surrogate mother.

Within the constructs of reproductive tourism, Indian women are typically being used by couples of other races or ethnicities. Surrogate mothers, "...are becoming less white than" the commissioning parents, and thus it is arguable that they have less claim to the surrogate child (Spar, 2005: 301). According to Spar, "[a]s the market expands to 'source' surrogates from Poland or India or Mexico, this discrepancy is almost certain to widen, adding to the vast gulf that already divides rich nations from poor" (Spar, 2005: 301). This physical distance coupled with the geographical separation may enable a distancing between the gestational surrogate mother and the child as well as between the gestational surrogate and the couple, which may be desirable for all parties involved.

Exploitation and the Commodification of the body

With the potential to commodify individual bodies, particularly in sexual terms, concerns of exploitation arise. Some argue that gestational surrogacy is not exploitive. However, since it is often those women of lower socioeconomic status who are most often used as gestational surrogate mothers, many feel this may lead to their easy access and exploitation. Hence, exploitation and the commodification of the body are dominant critiques of surrogacy practices. Exploitation can be understood as, "...a relation between A and B in which A (the exploiter) takes advantage of a situation involving B (the exploited) in an unfair or "inappropriate" way, which is made possible because A is in some way in a superior position" (Jorgensen, 2000: 39). While not exclusively, most often these concerns are focused on commercial surrogacy. Commercial surrogacy has caused the greatest concern in terms of exploitation because it is argued that the women are being paid for their services, which is likened to paying for their labour and production of the child. Surrogacy has been argued to be the selling of one's body (Sistare, 2001: 585) and comparisons have been made between commercial surrogacy, prostitution and slavery (Reilly, 2007: 483; Sistare, 2001: 585). According to Ber, "[s]ince, in the majority of cases, the main motivation is money, commercial gestational surrogacy has been compared with prostitution. In both cases a woman's body is treated as a commodity" (Ber, 2000: 161). Commercial surrogacy has been framed as "baby selling" (Markens, 2007: 83; Shevory, 2000: 66) and "womb renting" (Ber, 2000: 162). This is because in commercial gestational surrogacy the child born is "delivered to its genetic parents for a fee" (Ber, 2000: 162). The woman who carries and gives birth to the

child is solely being used as an incubator for the couple thus fulfilling strictly the biological or physiological aspect of reproduction (Goslinga-Roy, 2000: 121). Since it is the social expectation that the mother has a genetic relationship with the child, it can be argued that, "...the gestational surrogate mother is really a "womb for rent" (Ber, 2000: 162). Some argue that this is how gestational surrogate mothers have come to be advertised all over the world in newspapers, phone books and the internet (Ber, 2000: 162).

To contest accusations of "baby selling" brokers argue they are selling a service and not babies (Markens, 2007: 85) and the surrogate is not paid for producing a child, but rather for her services, her time, her risk and her discomfort (Ber, 2000: 162). However, it can be argued that gestational surrogacy is exploitative as the surrogate is forced into her decision by economic needs (Wilkinson, 2003: 172). Individuals who are exploited are often, *"...under-rewarded* for some thing that they provide to the person or institution that exploits them" (Wilkinson, 2003: 174-175). According to this perspective the gestational surrogate mothers have been underpaid for their involvement in relation to the physical and psychological risks they face throughout the process and the presumed benefits to the commissioning couple (Wilkinson, 2003: 179-180).

Since commercialized gestational surrogacy is a financial transaction, Spar argues surrogate motherhood "is fundamentally a business" which has grown dramatically in the last twenty years and the demand for these services will increase as the technology improves (Spar, 2005: 289). Despite living in a "consumer-oriented culture", we continue to avoid "...equating kinship formations with commercial transactions" (Markens, 2007:

182). Babies are supposed to arise from love, not commerce (Spar, 2005: 288). Many have argued that commercial surrogacy threatens children by "transforming them into commodities" (Markens, 2007: 69; Shevory, 2000: 65) and so the relationships between parents and children are said to suffer (Reilly, 2007: 483). In this view, children should not be viewed as commodities (Reilly, 2007: 483) through commercial surrogacy since this is against the "children's best interest" (Markens, 2007: 69).

Some argue that in order for surrogacy to become "less exploitive" the surrogate mother must be given "generous" financial compensation (Field, 1988: 26; see also Sistare, 2001: 589). The less the surrogate is paid the more exploited the surrogate and the most exploitive scenario is the one in which the surrogate is paid nothing at all (Field, 1988: 26). Conversely, offering to pay the surrogate mother and the higher fees the surrogate mother will receive will result in an increased difficulty for a potential surrogate to resist, particularly those who do not have similar money yielding options (Field, 1988: 26).

While many argue that surrogacy is exploitative, some make the argument that there has not been any actual proof that such women are being exploited through surrogacy contracts to an extent that would be greater, "... than economic necessity in general exploits them by inducing them to accept lower-paid [work]" (*Johnson vs. Calvert,* 1993: 785). Banning commercial surrogacy will not really help, as such women would only have to find a different job which may be just as exploitive, or simply stay poor (Wilkinson, 2003: 185). According to Sistare, "[w]e do not, as a society, bemoan the fate of women who work as domestics or in truly degrading service and industrial

jobs for minimum wages" (Sistare, 2001: 588) and so we should not complain about surrogacy in these terms either. Surrogacy may not, in fact, be a bad 'job'. As a surrogate mother, a woman is able to live at home, raise children of her own, and access good medical care (Sistare, 2001: 589). Since surrogacy is not the only potentially exploitive job women can have, as a society we may be able to justify it. Those who would agree to act as a surrogate mother may not be able to earn money in another way or perhaps only be able to earn money in more exploitive positions (Wilkinson, 2003: 186). Furthermore, some argue that by not allowing women to be paid for surrogacy, it is oppressive to women as it devalues women's labour (Markens, 2007: 63-64).

Some stress the notion of surrogacy as a gift (Markens, 2007: 85). Such authors argue that altruistic feelings play an important role for women who become surrogates (Shevory, 2000: 67-68). In Canada, altruistic surrogacy is permitted. Furthermore, Dr. Patel appears to have begun working with altruistic surrogacy (as can be observed in her first case of cross-border surrogacy as mentioned in the introduction). However, acting as a gestational surrogate mother for altruistic reasons is often less attractive than surrogacy for money (Spar, 2005: 294). Jorgensen argues that altruistic motivations are in fact disadvantageous for potential surrogates as they are not profiting financially for their services (2000: 41-42). While most people argue that non-commercial surrogacy is not exploitive, some disagree. Altruistic surrogacy has been criticized for creating a "false consciousness" (Shevory, 2000: 69) and some argue that women may be emotionally manipulated into becoming surrogate mothers (Anleu, 1992: 45). Jorgensen writes, "[a]ltruism can be the result of a social order that has limited women's options and of a

process of socialization that forces a specific self-conception upon women (2000: 42; see also Shevory, 2000: 69). Others argue that women have been socialized to be altruistic and so those women who cite altruism as their motivation to act as a gestational surrogate mother are merely reflecting their socialization to be caring, nurturing and "baby makers" (Shevory, 2000: 69). This means that women may be socially forced into becoming a surrogate rather than actually choosing for themselves (Jorgensen, 2000: 41). Thus those involved in altruistic surrogacy arrangements may be just as exploited, or possibly even more so, than those involved in commercial surrogacy arrangements (Anleu, 1992: 45; Shevory, 2000: 69).

Developed countries have come to be cultures largely based on consumption (Markens, 2007: 182) and capitalism (Sistare, 2001: 588). Female reproductive capability renders the female body vulnerable to commodification and regulation (Sharp, 2000: 299). This has come to be understood as a major reason why reproductive technologies have come to thrive in countries such as the United States (Markens, 2007: 182). One does not necessarily have to be harmed in order to be exploited (Wilkinson, 2003: 174). And in fact, the surrogate mother may even be understood as benefiting from her involvement (Wilkinson, 2003: 174).

Some feminists understand gestational surrogacy as evidence of women's continued exploitation in a patriarchical society (Ber, 2000: 163-164). Most often surrogacy is framed as exploitative, and great concerns have arisen regarding the development of a class of "breeder women" (Field, 1988: 30) and the emergence of a " baby breeding industry" (unknown speaker, *Surrogate Parenting Hearing* 1987: 168 in

Markens, 2007: 60). Gestational surrogacy can be understood as exploitative and coercive, as the surrogate mother would not have participated had she not had less power than her exploiter (Lee & Morgan, 2001: 207). While these concerns of exploitation and the commodification of female bodies with relation to surrogacy have developed in the West, they clearly apply to the use of Indian gestational surrogate mothers, as will be examined in my analysis.

Choice

Like many discussions on women's reproductivity, the question of women's freedom of choice is raised in concerns on gestational surrogacy. 'Choice' arises as both a concern as well as a solution to the potential for exploitation in many discussions of gestational surrogacy. Advocates of surrogacy tend to argue that women should be allowed to bear children for infertile couples (*Johnson vs. Calvert,* 1993: 791) and often refer to free choice values and the right to govern one's own body with respect to entering into surrogacy contracts (Reilly, 2007: 483). Some argue that the freedom to make one's own choice must be used to guide the moral concerns in the resolution of surrogacy debates (Sistare, 2001: 584-585). Thus such proponents believe that women have the right to make their own decisions as to how they use their own bodies (Markens, 2007: 50).

In order to respect a woman's right to choose, the freedom to become a surrogate is something that must remain an option (Markens, 2007: 57). Society already allows bodies to be treated as property, for example people sell their blood and sperm and are encouraged to exchange their labour for money (Sistare, 2001: 585). Women are capable

of making decisions about their own bodies. As long as the decision is voluntary, she should be required to fulfill her contractual obligations to give up the baby produced as a result of a surrogacy agreement (*Johnson vs. Calvert,* 1993: 791; see also Lee & Morgan, 2001: 208). Allowing the potential surrogate mother to have the choice, it can be argued, will allow surrogate women to operate as "autonomous moral and economic agent[s]" (Carmel Shalev in Lee & Morgan, 2001: 208). To make surrogacy illegal would be to limit women's freedom of bodily choice (Ber, 2000: 164) and not allowing women to make their own choices violates women's rights to choose what they do with their own reproductive capacity (Sistare, 2001: 586).

Conversely, opponents of surrogacy often argue that women are not truly making their own choice as their consent is not completely informed or voluntary and they may be coerced (Sistare, 2001: 586). As is often the case, it is those who are economically disadvantaged who participate as gestational surrogate mothers (Sharp, 2000: 302; see also Goslinga-Roy, 2000: 138). Since surrogates tend to have much lower incomes than those who hire them, surrogates are arguably more susceptible to coercion (Damelio & Sorensen, 2008: 269). Paid surrogacy may interfere with the validity of potential surrogates' consent (Wilkinson, 2003: 181). After finding in her study that the commissioning couple most often belonged to the professional class and the commissioned surrogate mothers were either housewives or working class, Eichler argues that money is, "..*the* major reason" that women agree to become surrogate mothers (1994: 202). Thus surrogacy may appeal to financially underprivileged, desperate women (Wilkinson, 2003: 181).

Coercion, however, is not present simply in economic terms. As Anleu argues, the further possibility exists that women are emotionally manipulated into surrogacy arrangements (1992: 45) and some suggest that guilt can be understood as a more powerful incentive than financial incentives (Jorgensen, 2000: 44). Thus coercion "may be subtle" and may exist in situations where the surrogate and commissioners have close social relationships (Reilly, 2007: 484).

Opponents of surrogacy also argue that women who enter into surrogacy contracts will lose their autonomy over their bodies and their potential parental rights (Markens, 2007: 50). The concern over a gestational surrogate's right to maintain parental rights after the birth of the child is an important one. With reference to the *Johnson v. Calvert* case it can be argued that since the courts deemed the Calverts to be the 'natural' parents of baby Christopher based on his genetic connection to both of them (Grayson, 2000: 99), this takes away the surrogate mother's choice with regards to breaking her contractual obligations and giving the child to the genetic parents. From this perspective, upon entering a surrogacy contract the woman no longer has the right to control her own body and its use for reproduction (Markens, 2007: 50). Thus, there is concern that surrogacy contracts will infringe on the freedom of women's right to choose (Markens, 2007: 51).

Both supporters and opponents of surrogacy express their arguments with reference to a "woman's right to choose" (Markens, 2007: 50). Concerns over whether or not a surrogate mother is truly autonomous have been a source of some debate (Ber, 2000: 159). While some argue that surrogate mothers are capable of choosing and should

be allowed to make their own reproductive decisions, others feel that surrogate mothers cannot truly make such a choice. The question of choice, however, is not exclusively for surrogate mothers. There is no question that the advances in ARTs have led to an increase in reproductive choice (Vandervort, 2006: 439) for those who are financially and socially able to use them. One no longer has to immediately accept their physical inability to have children, but can now survey a variety of medical procedures which may enable them to have a biologically related child. The freedom to employ a surrogate, it has been argued, is a freedom which should be respected (Sistare, 2001: 587). Furthermore, people desiring to use reproductive technological services, such as gestational surrogacy, are no longer confined to their home countries. Western people now have the choice as to what services are best suited to their needs, where to obtain such services (locally and globally) and to some extent what price they are willing to pay for their desired services.

Law

Legal issues are another important aspect to consider in the development of reproductive tourism. Laws not only help to shape the discourse surrounding reproductive tourism, but also have real world effects on people's lives. Laws may regulate the aspects within gestational surrogacy arrangements deemed exploitive, shape people's reproductive choices or reflect what is socially acceptable in a country. In relation to gestational surrogacy, laws can be used to resolve custody disputes and work to determine legal parenthood. Furthermore, laws may be useful in either preventing or regulating reproductive tourism.

New reproductive technologies have transcended the private realm of "reproductive decision-making" into "the public realm" and hence have become a legitimate legal concern (McTeer, 1995: 900). Generally, legislation as a response to the developments in ARTs has been slow (Spar, 2005: 290) and this can be understood in part as a lack of social consensus as to how such technologies should be legislated (Markens, 2007: 16-17).

Opponents of surrogacy have proposed a complete ban on gestational surrogacy as the only morally acceptable way of legislating surrogacy (Markens, 2007: 81). The basis of this argument is that surrogacy is exploitative, consists of baby selling and is morally wrong. However, some argue that regulations and ethical guidelines may be the best means to control this ever developing industry. Regulating the practice of surrogacy, it can be argued, may standardize practices and address health and safety issues, can respond quickly to changing circumstances and may help to educate and communicate with the public (Young, 2001: 47). Ethical Codes and Guidelines can, "...provide a framework of standards for the service providers closest to these issues" and ensure discussion of the issues (Young, 2001: 48-49).

Legal sanctions are not necessarily the best way to deal with new technologies. Like anti-abortion laws, laws surrounding new reproductive technologies invoke emotional responses and will be difficult to generate a consensus on, possibly rendering them unenforceable (Young, 2001: 43). Criminal sanctions may in fact make the situation worse as they may force such technologies underground (Young, 2001: 45), causing safety concerns for women. To avoid problems we need to preserve the right of

all individuals to reproduce, and so legalization and regulation are reasonable solutions (Markens, 2007: 81). Those arguing for the legalization of commercial surrogacy have argued that women should have the legal right to sign contracts that agree to pay them for their "gestational labour" (Damelio & Sorensen, 2008: 269). Some take the legalization of surrogacy one step further. Damelio and Sorensen argue that states which allow surrogacy should require the surrogate to participate in a class on contract pregnancy in order to legalize the contract (2008: 269-270). Damelio and Sorensen argue that "[t]he class will improve the surrogate's opportunity to make an autonomous decision and guard her right to make choices about reproduction and her body" (2008: 270). Others argue in favour of legalizing commercial surrogacy as this will ensure that the "best-interests-of-children" will be met by preventing custody disputes as parental rights would be defined (Markens, 2007: 70).

The development of reproductive tourism has led to international concerns in terms of its regulation and control. According to Blyth and Farrand,

> [c]entral to the debate on reproductive tourism is the question of the appropriate balance to be struck in a democratic state between the moral views of the majority and the individual human rights and freedoms; whether it is legitimate to restrict an individual's reproductive autonomy and, if so, to what extent such restrictions may be applied (Blyth and Farrand, 2005: 102).

Surrogacy arrangements are crossing borders and so regulation is needed not just on a national but also an international scale (Spar, 2005: 306). Some argue for a harmonization of standards worldwide. Since people now have access to services in

other countries, national regulations will likely not be effective (Deech, 2003: 425). Thus, international legislation needs to not only be created but also enforced (Deech, 2003: 430).

Others, however, argue that such harmonization is dangerous. National (and by extension international) regulation will not be effective and may prevent individuals from making their own choices (Deech, 2003: 425), thus violating one of our society's most dearly held rights and possibly some laws (Deech, 2003: 427). Those in favour of "legislative harmonization" tend to believe that others should accept 'our' laws (Pennings, 2004: 2692). Such harmonization is in danger of creating legislation which is more restrictive with respect to reproductive technology and presumes a common world view (Pennings, 2004: 2689; 2692). This then, fails to reflect any form of pluralism (religious, cultural or ethical) (Pennings, 2004: 2689). This may be avoided by making legislation on "broad ethical principals" or by avoiding legislation of moral issues and focusing instead on safety and quality concerns. Following this view, we should focus on "licensing and controlling centres of assisted reproduction" in order to maintain standards (Pennings, 2004: 2692).

Legal response to the use of ARTs and in particular gestational surrogacy vary between countries. Some countries have dealt with such technologies by simply not implementing laws at all. For instance, Belgium has no assisted reproduction laws (Pennings, 2004: 2690). Similarly, legislative officials in the United States have resisted dealing with surrogacy issues (Spar, 2005: 290) and the most common response has been "a lack of legislation" (Markens, 2007: 27). Those who have surrogacy laws have often

focused on banning surrogacy or not recognizing surrogacy contracts (Markens, 2007: 30; Spar, 2005: 290). The March, 2004 Italian law totally banned donor procedures, limited the number of oocytes which can be fertilized and replaced to three and prohibited surrogacy (Pennings, 2004: 2690; Blyth and Farrand, 2005: 96). Many, if not most, of the Industrialized countries including, "Australia, Canada, Denmark, France, Germany, Great Britain, Italy, the Netherlands, Norway, Spain, Sweden, [and] Switzerland" have either rejected or restricted surrogacy practices and have implemented national legislation that discourages or prohibits surrogacy (Markens, 2007: 23; Spar, 2005: 290). While the Australian Capital Territory allows altruistic surrogacy (Reilly, 2007: 483), in 1984 Australia banned surrogacy, surrogacy brokers, contracts and promotions (Spar, 2006: 83). The United Kingdom also permits altruistic surrogacy (Reilly, 2007: 483), however, in 1985 the British government passed the Surrogacy Arrangements Act which bans commercial surrogacy and makes organizing a surrogacy contract illegal (Spar, 2006: 83). Furthermore, nations such as the United Kingdom and Germany have also imposed criminal sanctions (Markens, 2007: 23). Both Germany and France have banned all forms of surrogacy contracts based on the belief that the human body cannot be subject to contractual agreements (Spar, 2006: 83). Conversely, commercial and gestational surrogacy is legal in Israel but familial and altruistic surrogacy is prohibited based on religious reasons which are related to concerns of incest and adultery (Reilly, 2007: 483; Spar, 2006: 85).

In contrast to the above mentioned industrialized nations, the United States has not adopted any type of national surrogacy legislation, but has left the legislation up to

the individual states (Markens, 2007: 23; Spar, 2006: 84). The responses of the states have been quite varied, with many of the U.S. states having banned all types of surrogacy (Reilly, 2007: 483). According to Markens, "[f]ew [American] legislatures have kept pace with the growing popularity of surrogacy. As of 1992...only fifteen states had enacted laws specifically addressing surrogacy, and only Washington, D.C., and two states have passed legislation since then" (Markens, 2007: 4)[9]. Since surrogacy legislation has been scarcely developed, many disputes related to surrogacy and surrogate parental rights have ended up in the judicial system (Markens, 2007: 27).

Most of the existing American laws regulating or defining parenthood are inadequate for use in surrogacy cases as they were created for other uses such as adoption or donor insemination (Markens, 2007: 27). This can be seen in the case of *Johnson vs. Calvert*, as already discussed, as well as in the *Jaycee* case. In the *Jaycee* case, Pamela Snell agreed to act as the gestational surrogate mother for John and Luanne Buzzanca using donated sperm and ova (Bhattacharyya, 2006: 77-78). However, in March of 1995, John Buzzanca filed for divorce and claimed no responsibility for the child in utero (Bhattacharyya, 2006: 78). On April 26, 1995, Jaycee Louise Buzzanca was born and willingly given up by Pamela (the gestational surrogate) to the intended mother, Luanne (Bhattacharyya, 2006: 78). After the birth of Jaycee, Luanne filed for

[9] Michigan courts decided that commercial surrogacy is illegal as it is comparable to commercial adoption which is illegal (Spar, 2006: 84). The Kentucky court disagrees and does not see commercial surrogacy as "baby selling" "as long as the contract was entered into *before* pregnancy" (Spar, 2006: 84). Texas passed a law in 2004 that "...allows for and regulates surrogate parenting arrangements" (Markens, 2007: 27). New York's legislation is designed to "discourage surrogate parenting" with a complete ban on commercial surrogacy and declaring surrogacy contracts unenforceable (Markens, 2007: 4). Whereas California legislation is, "...designed to regulate the practice in order to allow it to continue with as few problems as possible" (Markens, 2007: 4).

sole custody of the child and requested child support payments from John during the legal processes (Bhattacharyya, 2006: 78). While John did not dispute the fact that he had signed the surrogacy contract, he argued that, "... the California Family Court lacks the jurisdiction to force him to pay child support because, according to its own definitions, it cannot establish that Jaycee is indeed a "child of the marriage" (Bhattacharyya, 2006: 78). The original trial court judge, Robert D. Monarch, concluded that "Jaycee had no lawful parents" (Bhattacharyya, 2006: 79; Markens, 2007: 1). Neither the gestational surrogate mother nor her husband were the biological parents of Jaycee, Luanne was not the child's mother as she neither gave birth nor was she genetically related to Jaycee and she had not yet legally adopted the child. Furthermore, John was not to be considered as Jaycee's father as he did not contribute to her conception biologically and he had not legally adopted her (Bhattacharyya, 2006: 79). However, upon appeal Judge Monarch's ruling was overturned arguing that, "...even in the absence of genetic or biological relationship, parental relationships may be established when the intended parents initiate and consent to reproductive medical procedures" (Bhattacharyya, 2006: 79). Thus, like *Johnson vs. Calvert,* the social parental intention was used as the deciding factor in determining parental responsibility. Thus parental intention has become a very important factor when deciding parenthood in gestational surrogacy cases. Overall, this legal battle provides evidence to claims that social and legal policies have yet to catch up to the dilemmas developing out newly developing ARTs, and also in particular relation to surrogacy arrangements (Markens, 2007: 2, 27).

Unlike European countries, the United States government has been cautious with respect to imposing federal legislative limitations on ARTs. Instead, they have preferred to leave these issues to the courts and state legislature (Spar, 2006: 228). The U.S. government's reluctance to create national laws is a reflection of a fear of ethical and religious entanglement (Spar, 2006: 228).

In Canada, however, the *Assisted Human Reproduction Act,* which regulates many aspects of reproductive technologies, was passed in 2004. According to this act one cannot pay or "offer to pay" someone to be a surrogate mother, nor can one "advertise that it [surrogacy] will be paid" (s. 6(1)). A person cannot advertise, offer or accept payment for arranging a surrogate mother for a commissioning couple (s. 6(2)). Nor can one advertise for or offer payment for the arrangement of surrogacy services and cannot advertise in any way that they will pay for it (s. 6(3)). However, "The Assisted Human Reproduction Act does not address whether surrogacy agreements are valid, and Canadian case law has yet to address the issues of a custody dispute between a surrogate mother and commissioner(s)" (Reilly, 2007: 484). The Act is silent on altruistic surrogacy, and this still occurs in Canada. Of all Canadian provinces, Quebec alone has addressed the issue of surrogacy contracts and has declared such arrangements unenforceable (Reilly, 2007: 484).

Some understand reproductive tourism as a type of "safety valve" which "avoids moral conflict" and ultimately allows for, "...peaceful coexistence of different ethical and religious views" (Pennings, 2004: 2694). Blocking all access to ARTs, in part by not allowing reproductive tourism, may be dangerous as, "... it could increase feelings of

frustration, suppression and indignation" (Pennings, 2004: 2694). Since ARTs are difficult to deal with in terms of ethics and legislation, those who are unable to obtain particular services in their home countries could make use of the availability in other states or countries. In doing this, it may prevent outrage from those who otherwise would not be able to obtain such services. Allowing people to travel to other jurisdictions to obtain their desired medical fertility treatment enables individuals to make their own reproductive choices, while at the same time allowing particular jurisdictions to legislate ARTs as they see fit.

Much needs to be accomplished in terms of legal regulation with respect to gestational and commercial surrogacy at the national and international levels. According to one Indian Women and Child Development minister, "[t]he sensitive issue of surrogacy in the absence of laws or regulations has become a free playing field for unscrupulous intermediaries who lure and push uneducated and poor women into surrogate motherhood" (Singh, 2007: 1). Thus, some legal regulation can be said to be needed in order to regulate the practice of gestational surrogacy, particularly in its commercial form, to safeguard the rights and interests of those involved.

Conclusion

This chapter has discussed the cultural context in which reproductive tourism has developed as well as the development of critical aspects in Western gestational surrogacy debates which have now come to apply to Indian gestational surrogacy tourism. Cultural understandings of motherhood and infertility have led to the development of ARTs, which in turn, reiterate the importance of motherhood and the undesirability of infertility

in Western culture. The world has become increasingly globalized and world markets seem to be without boundaries, including the market for health care and thus reproductive services. Surrogacy in the West has been a source of debate. While some focus their concerns on class, race or ethnicity, others centre on debating whether or not surrogacy is exploitive and commodifies the human body. Still other debates have arisen, arguing over issues of choice as they relate to surrogacy. Since it is framed as an ethical debate, no consensus has been reached on these issues. Hence, surrogacy in the West has been difficult to deal with in legal terms and is likely to continue to be difficult with respect to reproductive tourism, and particularly Indian gestational surrogacy tourism.

Now that we understand how Indian gestational surrogacy tourism has developed and how debates surrounding gestational surrogacy have been shaped, we can move on to an analysis of this practice. I now turn to a discussion of my methodological approach in analysing Indian gestational surrogacy tourism.

Chapter Two: Methodology
Feminist Critical Discourse Analysis

We have seen how the discourses and socio-cultural constructions of motherhood, infertility and ARTs, as well as the racial and class issues surrounding surrogacy, issues of exploitation and the commodification of the body, and issues of choice have come to define the debate around gestational surrogacy. In using a feminist critical discourse analysis to examine popular media discourse surrounding Indian gestational surrogacy we can learn how this issue has come to be understood as a master narrative. Through this I hope to gain an understanding of why this is occurring and how it has come to be understood by Western and Indian societies. Thus, this chapter presents the theoretical and methodological framework of my analysis of Indian gestational surrogacy tourism.

Critical Discourse Analysis (CDA) and Feminist Critical Discourse Analysis

A feminist critical discourse analysis is the chosen method to study the topic of Indian surrogates being hired by Western couples. The goal of this paper is to understand the master narrative of gestational surrogacy and in particular the master narrative of 'outsourcing the womb' to India by examining the media discourse on Indian gestational surrogacy tourism.

According to Fairclough (2006), "[d]iscourse is a moment of social events which is dialectically interconnected with other moments" (30) and are ways that aspects of social life are represented (31). Discourse analysis is, "*the systematic and explicit analysis of various structures and strategies of different levels of talk and text*" (Van Dijk, 2007 cited in Wodak, 2008: 3). Critical discourse analysis is committed to an

examination of the relationship that exists in the function of and the form in communication (Renkema, 2004: 1 cited in Wodak, 2008: 1), offers a framework for analysing social research that is problem-orientated (Wodak, 2008: 2) and is generally concerned with issues of social injustice and social inequality (Lazar, 2005: 2). Discourse analysis focuses not on individual words but rather "*larger units*" (Wodak, 2008: 3) of interaction (Wodak, 2008: 4). According to Norman Fairclough, the goal of critical discourse analysis is to:

> Systematically explore often opaque relationships of causality and determination between (a) discursive practices, events and texts, and (b) wider social and cultural structures, relations and process; to investigate how such practices, events and texts arise out of and are ideologically shaped by relations of power and struggles over power" (Fairclough *Discourse and Social Change* 1992 in Locke 2004: 1).

Critical discourse analysis understands social order to be situated historically and constructed through the use of discourse. Subjectivity is shaped in part by discourse and discourse is produced out of ideology. The creation of power relations is inevitable due to the privileged status of some individuals over others (Locke, 2004: 1-2). Since this is inevitable, critical discourse analysis is concerned with how power relations are created by discourse and how they are maintained or, conversely, challenged through various texts (Locke, 2004: 38). There is a dialectical relationship between the social world and discourse (from Fairclough, 1992; 1995 cited in Lazar, 2005: 11; see also Fairclough, 2006: 13). Critical discourse studies can show how social assumptions and power

relations are produced in discourse and how they are perpetuated or challenged (Lazar, 2005: 2). Critical discourse analysis ultimately works towards social transformation and emancipation (Lazar, 2005: 1).

Combining critical discourse analysis and feminism can create a "...rich and powerful political critique for action" (Lazar, 2005: 5). Feminist critical discourse analysis is a political perspective focused on gender and concerns itself with understanding the discursive relationships between gender, ideology and power (Lazar, 2005: 4). A central concern in feminist critical discourse analysis is providing a critique of the discourses that continue "patriarchal social order" which ultimately privilege men and disempower women (Lazar, 2005: 5). Furthermore, it examines how power relations are produced discursively and how they are resisted through textual representations that focus on gendered social practices (Lazar, 2005: 1). Feminist critical discourse analysts argue that we need to theorize and analyze the gender as an oppressive force (Lazar, 2005: 3). From this perspective, discourse is understood as the "site of struggle, where forces of social (re)production and contestation are played out" (Lazar, 2005: 4).

A feminist critical discourse analysis is a useful approach to an emerging social practice such as reproductive tourism. The emphasis on historical situatedness in such analysis provides an opportunity to look behind the 'newness' of the practice to the social norms and ideological beliefs such practices may both reinforce and challenge. Furthermore, this type of analysis will be useful in identifying how power relationships are produced and resisted in media representations and this understanding may enable social transformation and liberation. This form of analysis can be helpful in showing

binaries which can then be opposed (Locke, 2004: 59) and can be helpful in determining what the discourses are surrounding the topics of reproductive tourism and the "outsourcing of the womb" to India. This may lead to an understanding of how the issue is understood (and is made to be understood) by the public. Within the master narrative of Indian gestational surrogacy, there are discursive frames which compete with each other, however, they are not all equal and some are socially considered more important than others (Kelly, 1996: 423). A feminist critical discourse analysis may be able not only to determine the existing discursive frames within the master narrative of Indian gestational surrogacy, but may also work toward understanding the implications of such representations and help to explain what factors have lead to such a practice.

The Master Narrative

Pamela Downe's discussion of the "master narrative" in the sex trafficking trade explains why the analysis of discourse is important. For Downe, the master narrative is the dominant, hegemonic understanding of a particular situation. Because it is the hegemonic understanding of a situation, it is difficult to overcome. Downe argues that we must work to get away from this script in order to understand the situation more clearly (2006: 566-567). I would argue that Indian gestational surrogacy tourism has its own master narrative. Indian gestational surrogacy tourism is presented as an ethical debate which generally places arguments for and against Indian gestational surrogacy tourism against each other. While this master narrative does have two opposing sides, the fact is that it is continually presented in terms of such ethical debate, almost as a dilemma that cannot be resolved, thus warranting an understanding as a master narrative. Within

this master narrative, are discursive frames which argue for or against the use of Indian gestational surrogate mothers by foreign couples. I refer to the master narrative of Indian gestational surrogacy tourism as an *ethical master narrative.*

Analysing Indian Gestational Surrogacy Tourism

The world has entered a time of global communication (Fairclough, 2006: 99) and the mass media has become an increasingly important element of the distribution of news and information (Fairclough, 2006: 119-120) as well as global discourse. Van Dijk argues that the mass media maintain almost complete control over the resources which are needed to produce social consent (1991: 43 in Locke, 2004: 69). Hence, the media are "key cultural texts" (Kelly, 1996: 422) which have provided a rich source of information as representations of the discourse. High circulation media reflect the social mainstream (Mautner, 2008: 32), and so this broadcasting to an extremely large audience enhances the ability to shape the construction of reality (Mautner, 2008: 32). News reports in any form are structured and filtered through "economic, political, cultural and social structures" (Mautner, 2008: 33) and journalists' work often reflects the dominant positions as taken from those in control of the media sources (van Dijk, 1988: 120 in Mautner, 2008: 33). Thus it is inevitable that news reports tend to favour those in powerful positions (Mautner, 2008: 33), resulting in the establishment of a dominant worldview (Fairclough, 1995: 49 in Mautner, 2008: 33).

Because mass media has come to play such an important role in the daily lives of people worldwide, print media has been a rich source of information. The ubiquity of mass media, the public attention it receives as well as its political influence all make

media representations interesting and useful to study (Mautner, 2008: 32). Other advantages of using print media include its ease of collection and that the observer's paradox is not an issue of concern as the text itself does not change when read (Mautner, 2008: 32). Furthermore, media tends to presents the dominant, "...beliefs, values and attitudes and the political process and processes of political legitimization..." (Fairclough, 2006: 30).

I believe that using this qualitative method in examining the cultural representations of Indian gestational surrogacy is a good place to begin to understand the issues involved. Since media representations are rich sources of cultural understandings of any issue, a feminist critical discourse analysis is an appropriate method to study the development of reproductive tourism as it relates to India.

Through my analysis of eighty one media representations I have examined the ethical master narrative and the discursive frames that exist within the master narrative of Indian gestational surrogacy tourism. I have focused on print media such as newspaper articles, magazine articles and websites as well as a transcript from *The Oprah Show* which focused on an American couple traveling to India to hire a gestational surrogate mother. More specifically, I have used newspapers and magazines such as the *New York Times,* the *Globe and Mail, The Star, The Record, Newsweek, Macleans, The Times of India,* and the United Kingdom based *Guardian, The London Evening Standard* and the *Independent* since there is a large Indian population in the United Kingdom. I have included two particular websites, the Akanksha Infertility Clinic and Rotunda–The Center for Human Reproduction, both Indian infertility clinics which provide access to

international surrogacy services. In addition to these sources, I have used internet search engines to conduct key word searches using terms including "Indian surrogacy", "surrogacy, India" "reproductive tourism-India" and "gestational surrogacy – India".

While I did go through actual print copies of *Macleans* and *Newsweek,* as I purchased subscriptions to both, my internet search of newspaper articles and websites proved to be more useful in locating articles. This is likely because this issue is not one which is often discussed on an ongoing basis, but rather one that appears as a 'special report'. However, this is not true in all cases. *The Times of India* as well as the *London Evening Standard* have published numerous articles reporting Indian gestational surrogacy tourism, and this likely reflects the growing concerns about the practices in India and the United Kingdom.

I only included those articles which specifically discussed reproductive tourism to India. While articles about other destinations exist, I chose to focus on India. Articles were found by reading daily headlines of the mentioned newspapers, through internet search engines, as well as through the notification features of the *Globe and Mail*, and Google. I imputed key terms into the notification engines, where such services were offered, in order to produce notifications. Key terms included "Surrogacy", "Gestational Surrogacy" "Surrogacy in India" "Reproductive Tourism" "Wombs for Rent" and "Outsourcing". In addition I set up a daily notification of all news headlines in the *New York Times* and read through these for related discussions.

In my analysis some guiding questions included: how is Indian gestational surrogacy presented in the discourse?; what is the dominant way the discourse has come

to represent this issue (what is the master narrative?); since I have found the master narrative to be an ethical master narrative, how is this narrative represented?; what are the discursive frames within this ethical master narrative that exist? Do they argue for or against Indian gestational surrogacy tourism?; and finally how does this explain how and why Indian gestational surrogacy has developed?

I began reading my articles simply to gain an understanding of the representations. When analysing my articles, it was evident that the representations of Indian gestational surrogacy tourism were presented as an ethical debate, clearly indicating it as a master narrative. Under this ethical master narrative I began to notice that the arguments for and against this issue were evident as themes or discursive frames. I observed that many of the discursive frames seem to develop out of past gestational surrogacy debates in the West. After identifying the discursive frames, I re-read the articles and began to identify specific instances where they were represented in the discourse. This enabled a clear identification and understanding of the discourse representations of Indian gestational surrogacy tourism.

I have critically examined the discourses surrounding Indian gestational surrogacy tourism as presented in media discourse representations. I used a feminist critical discourse analysis approach and examined public discourse in order to uncover the master narrative of Indian gestational surrogacy tourism. Within the ethical master narrative of Indian gestational surrogacy tourism, I discovered discursive frames which focus on arguing for or against Indian gestational surrogacy tourism. Understanding the ethical master narrative as well as the discursive frames within the ethical master

narrative enabled an understanding of how and why Indian gestational surrogacy tourism has developed. Thus, using feminist critical discourse analysis and Downe's idea of the master narrative has enabled me to answer my research questions.

Chapter Three: Analysis

Representations of the Gestational Surrogate Mothers, Commissioning Couples and Understanding the Development of Indian Gestational Surrogacy Tourism

At a very basic level, Indian gestational surrogacy tourism can be understood as being at the centre of an ethical debate. Representations of Indian gestational surrogacy tourism construct it as a master narrative that frames it as an ethical debate, often pitting the arguments for and against Indian gestational surrogacy tourism against one another. Discussions of this new development in surrogacy have their basis in the earliest of surrogacy debates. A feminist critical discourse analysis of eighty-one newspaper articles, magazine articles and websites has revealed much as to how Western use of Indian gestational surrogate mothers is presented and understood in Western society as well as in Indian society. Furthermore it has also proven to be useful in showing new aspects of gestational surrogacy discourses with respect to the social construction of Indian gestational surrogacy tourism.

Like earlier accounts of surrogacy arrangements, there are two basic positions presented within the ethical master narrative, those for and those against use of such services. Some media representations provide the audience with both perspectives (Sharma, August 9, 2008, Haworth, 2008). Other media accounts mainly focus on presenting discourse either in favour (The Akanksha Infertility Clinic, Medical Tourism

Corporation, The Oprah Show) or against (Warner 2008, Mendick and Bhatia, 2009) reproductive tourism as it relates to India.

For this reason, the analysis has been divided into two chapters. The first analysis chapter focuses on the 'for' side of the master narrative of Indian gestational surrogacy tourism. It begins with an analysis of how both the Indian gestational surrogacy mothers and the foreign commissioning couples are represented through media accounts. Furthermore, the underlying ideologies which have played a significant role in the development of this reproductive tourist industry as well as more particular representations of the Indian gestational surrogacy business will be examined. Chapter five then turns to a focus on the 'against' side of the master narrative with a focus on representations which critique reproductive tourism with respect to India.

The first part of this chapter discusses how Indian gestational surrogate mothers are described as well as who is obtaining the services. It also discusses issues of access and who in particular has or does not have access to the services provided by Indian gestational surrogate mothers. The second part of this chapter moves on to focus on the underlying reasons for the use of Indian gestational surrogate mothers. Here, issues of the naturalization of reproduction, desperation, representations of hope and globalization are studied. Finally, I consider why India has become the popular destination for Western couples to travel to in order to hire gestational surrogate mothers. I have found that this has occurred for many reasons, including India's representation as a last resort destination, helping and altruistic beliefs, price concerns and governmental and legal issues. Additionally, both the ICMR and Indian fertility clinics place a particular focus

on presenting the fetus carried by the Indian gestational surrogate mother as not belonging to the gestational mother, and India itself has been presented as a country with a generous supply of gestational surrogate mothers.

Indian Gestational Surrogate Mothers, Commissioning Couples and Access

Understanding who provides and obtains gestational services is an issue of great importance. Generally, the key individuals in this are the Indian gestational surrogate mothers and those foreigners who come from wealthier countries (typically from Western countries) in order to commission the Indian women.

Representations of Indian Gestational Surrogate Mothers

An analysis of news reports discussing Western women hiring Indian gestational surrogate mothers has shown that typically Indian gestational surrogate mothers are described as women of Indian nationality currently residing in India, living impoverished lives. For reasons that will be discussed, these Indian gestational surrogate mothers also have families and children of their own. Media representations focus on the impoverished living conditions of such women and on their need for money in order to better their living conditions. Accordingly, Indian gestational surrogate mothers tend to be described as extremely poor and undereducated women. This relates to discussions as to how gestational surrogate mothers are generally represented. As Eichler notes, typically gestational surrogate mothers are from lower socio-economic classes. This understanding of gestational surrogates in general extends internationally to racial minorities, including to Indian gestational surrogate mothers (supra: 44-46). Indian women are often described as living in very poor housing situations, such as single

roomed, leaky mud huts. The money these women receive for acting as gestational surrogate mothers is typically cited as being used for increased financial stability such as obtaining a better home.

The influence of potential income can be seen in the particular case of the Indian gestational surrogate mothers. Haworth suggests that one woman, Vohra, an Indian gestational surrogate mother, has become a gestational surrogate mother because she and her family live an impoverished lifestyle (for instance living in a mud house) and the money will therefore be beneficial (2008: 2). Haworth writes, "[s]he plans to divide her surrogacy windfall three ways: buying a brick house, invest in her husband's business, and paying for her children's education" (2008: 2). Thus it is arguable that even if Vohra believes she has a choice of whether or not to become a surrogate mother, the fact that she feels she needs the money suggests that she is pushed into a decision she may not otherwise have made had she been more economically well off (see Spar, 2005: 299).

Other uses for this money include paying off debts, paying for their childrens' education and in a few instances providing dowries for their female children (despite the fact that it is illegal). These representations are supported by statements of fact by the women involved, "[f]rom the money I can earn as a surrogate mother, I can buy a house,...It's not possible for my husband to earn more he's not educated and only earns $50 a month" (Nandani Patel quoted via translator, Warner, 2008: 1).

Representations of Commissioning Couples

While Indian nationals do hire local women to act as gestational surrogate mothers, our concern here is with those individuals who travel to foreign countries to

obtain this and similar services. Those who take part in using Indian gestational surrogacy services and who are foreigners to that country are considered to be taking part in reproductive tourism.

It is important to note that reproductive tourism manifests itself in various ways, including commissioning couples traveling from developed countries to both developed and less developed countries. India, however, has become a major centre for foreign couples, with people coming "[f]rom all over the world" (Lisa Ling/Dr. Nayna Patel, *The Oprah Show*, 2008: 3) to enlist such services. According to news reports, "[c]linics that provide surrogate mothers for foreigners say they have recently been inundated with requests from the United States and Europe, as word spreads of India's mix of skilled medical professionals, relatively liberal laws and low prices" (Gentleman, 2008: 1).

The media presents the foreign users of these services most often as Westerners, "[a]n evening standard investigation today exposes the boom in Indian surrogate babies for childless Western couples" (Bhatia, 2009b: 1) and as desperate to have a 'child of their own' (supra: 22; *see the desperation of the infertile*). These foreign commissioning couples are usually described as "relatively rich foreigners" (Gentleman, 2008: 2) as is typical in gestational surrogacy agreements (supra: 44-46). Furthermore they are most often referred to as foreigners from countries such as the United States of America and the United Kingdom. To a lesser extent, couples from Canada, Australia and Germany are also noted as foreign commissioning couples. Some accounts also report that couples from Israel and Japan and from less developed nations such as Nigeria are using Indian gestational surrogates: "[s]o you have Germans and Canadians and Americans and

Nigerians, it's pretty impressive" (Lisa Ling, *The Oprah Show*, 2008: 3-4). These representations are made in part through the accompanying photos in the articles which clearly depict the race, ethnicity and nationality of the commissioning couples.

Some accounts have also noted heterosexual men as hiring Indian gestational surrogate mothers as a means to obtain biologically related children without an attachment to a woman (Divorced Man Adopts Surrogacy, 2005; Mendick(c), 2009). Thus, there is a wide range of commissioning parents traveling from all over the world to India in their desperate search for a genetically related child.

Issues of Access

Not all would-be commissioning couples have equal access to Indian gestational surrogacy services. Generally it is clear that foreigners and particularly Westerners are allowed access to hire Indian gestational surrogate mothers. However, access is not simply granted to all foreigners. Both the Indian Council of Medical Research (ICMR) and individual infertility clinics place barriers to commissioning individuals who are considered less than 'ideal' candidates for parenthood.

Firstly, those allowed to hire an Indian gestational surrogate are those women or couples who are understood as being infertile (Dolnick, 2007: 1). One article reports that according to the ICMR guidelines only those who are incurably infertile are allowed access to such services,

> [a]ccording to the guidelines [set out by the ICMR], the biological parents who provided sperm and ovum have to undergo diagnosis for the cause of infertility before they be [sic] allowed to have a surrogate baby. Further, they should sign an

undertaking to this effect that their infertility is incurable and, therefore, they are opting surrogation (Sharma, A. 2008: 1).

Under the ICMR infertility is understood as, "[f]ailure to conceive after at least one year of unprotected *coitus*" (*National Guidelines for Accreditation, Supervision and Regulation of ART clinics in India,* 2005: 1.2.20). Sharma's report is confirmed by the Ethical Guidelines for Biomedical Research on Human Participants put forth by the ICMR, "[s]urrogacy should be resorted to only if medically certified as the only solution to infertility or any other medical bar on pregnancy by the intending mother" (2006: 102). In order for one to be diagnosed as medically infertile, they must undergo very specific medical examinations as outlined in the *National Guidelines for Accreditation, Supervision and Regulation of ART clinics in India.* According to another reporter, the ICMR guidelines also allow surrogacy, "...when pregnancy can prove to be hazardous for the mother or the baby" (Utpat, 2009).

Access is also controlled by the clinics directly providing gestational surrogacy services. Medical Director and IVF Specialist Dr. Nayna H. Patel of the Akanksha Infertility Clinic is known to choose who has access to her clinic, "Patel said she carefully chooses which couples to help and which women to hire as surrogates. She only accepts couples with serious fertility issues" (Dolnick, 2007: 3).

While there are those who agree with the use of Indian gestational surrogates for medical reasons (i.e. its okay to use a surrogate if one cannot physically carry a child on their own) it appears that it is generally not accepted as a means for use by women who *do not want* to carry their own children for career or physical concerns such as the pain

of pregnancy and birth or in order to prevent weight gain. One reporter working for *The Times of India* notes,

> However, an increasing number of healthy, married working women are now making inquires about surrogate motherhood. Keen to be mothers and yet not willing to put their careers on hold, these career-driven women have given a new twist to the concept of outsourcing (Kaur, 2007: 1).

Dr. Nayna Patel says, "I've had some women ask to do surrogacy because they don't want to give up work for a pregnancy, but I turned them down flat" (Haworth, 2008: 3). Another doctor is quoted as saying "[w]e advise these women not to go in for surrogacy since medically they can conceive and deliver babies. We also tell them that a bond is formed between mother and child during pregnancy" (Dr. Sunita Tandulwakdar quoted in Kaur, 2007: 1). In one article written in *The Times of India*, one individual says, "[w]e turn down such couples because I strongly feel that if one wants to experience motherhood, pregnancy is a part and parcel of it" (Sunita Tandulwadkar, quoted in Utpat, 2009).

Here, the discourse also reflects an increasing concern with regards to women using surrogacy in order to circumvent the inconvenience of pregnancy. Kaur is not the only one to present this as a concern, "But if commercial surrogacy keeps growing, some fear it could change from a medical necessity for infertile women to a convenience for the rich" (Dolnick, 2007: 4). Dr. John Lantos also sees this as a concern and understands restriction of such services to be strictly reserved for those who are unable to reproduce independently of medical assistance, "[y]ou can picture the wealthy couples of the West

deciding that pregnancy is just not worth the trouble anymore and the whole industry will be farmed out" (Dolnick, 2007: 4).

Homosexuality is also used by some clinics as a reason to prevent access: "[b]ut she [Dr. Nayna Patel] refuses to treat gay couples, revealing her deeply conservative cultural roots…I get e-mails from gays and lesbians, …some of them very well written – but I don't feel right about helping them [homosexuals]" (Dr. Nayna Patel quoted in Haworth, 2008: 3) (supra: 26). It is not just medical criteria then, but also social criteria that restrict access to ARTs. This approach is not unique to Indian fertility clinics; Ikemoto found that American medical clinics screen potential clients on the basis of similar social criteria (1996: 1029) (supra: 26). However, not all Indian clinics exclude homosexual couples from attaining this service. Clinics such as the Rotunda clinic not only allow, but also promote, their services for the particular niche of homosexual couples. For instance, upon entering the Rotunda–The Center for Human Reproduction[10] website, one observes a video report promotion focusing on a gay Israeli couple who successfully hired an Indian gestational surrogate mother who gave birth to 'their' child.

It is clear, then, that access to Indian gestational surrogate mothers is guided in part by the personal morals and prejudices of the fertility doctors, as well as by medical criteria. Those in positions of privilege, such as economically advantaged, often white, heterosexual Western couples, have easy access to Indian gestational surrogacy services. However, those understood as having less social access power in this situation, including those seeking surrogacy by choice and homosexuals, have limited access. While it

[10] [http://www.iwannagetpregnant.com/default.asp]

appears that generally access to Indian gestational surrogate mothers is reserved for the medically infertile heterosexual couples, some clinics allow access to gay couples.

Understanding the Development of Indian Gestational Surrogacy Tourism.

Next, it is important to understand what underlying social constructions have led not just to the development of ARTs (supra: ch. 1) such as gestational surrogacy but also why this practice has come, in particular, to India.

The Naturalization of Reproduction

Wanting to have a child is culturally constructed as a natural human need in both Western and Indian society (supra: 11-12). Such naturalization is often reinforced publicly in news articles discussing international Indian surrogacy. For instance, Dolnick writes, "[b]ut the program raises a host of uncomfortable questions that touch on morals and modern science, exploitation and globalization, and that most natural of desires: to have a family" (2007: 1). In her article on the topic of local Indian women acting as gestational surrogate mothers for foreign couples, Goodman writes, "I don't make light of infertility. The primal desire to have a child underlies this multinational Creation Inc." (2008: 2).

Infertility discourse reinforces the unidimensional understanding of infertility as creating desperation for a child (supra: 19-27). Infertility as a devastating experience grounds commissioning couples' stories about traveling to India to hire a woman to act as a gestational surrogate mother as often as it grounds any use of new reproductive technologies, "[w]e always imagined having a family and being parents. And we just

couldn't imagine not having kids. But we knew that we wanted to have a family, somehow" (Jennifer West on *The Oprah Show* 2008: 3).

This naturalized need to have children, then, justifies an individual's nearly endless use of medical technology in order to do everything they can to have a genetically related child. Many people feel it is a natural need to have a genetically related child. Hence, many feel that it is acceptable to do anything possible to achieve that goal, even if it means hiring an Indian gestational surrogate mother because they cannot afford one, or cannot legally hire one, in their home country. The Western justification of the natural desire to have children also justifies the perpetuation of globalized hierarchical power relationships between the West and East, which continually places the East beneath the West.

Desperation

Desperation has come to be a key representation with regards to infertile Western people using Indian gestational surrogate mothers. Indian gestational surrogate mothers are also characterized as desperate. The infertile Westerners are depicted as having undergone a terrible ordeal in attempting to have a child. This desperation of the infertile is a familiar discursive theme in discussions of ARTs including gestational surrogacy. On the Indian side, gestational surrogate mothers are presented as impoverished women with husbands who make very little money. Thus, they are seen as desperately poor and are understood as agreeing to act as gestational surrogate mothers for Western couples in order to gain the financial means to build/buy a house, to pay for their children's future, and generally for the betterment of the entire family. This presentation of the desperation

of the Indian gestational surrogate mothers is new; gestational surrogates in America are not seen as rich, but neither as impoverished. Out of Indian gestational surrogacy tourism, then, a new discourse has been created which arises out of the ability of commissioning parents to travel and to hire very poor women.

The Desperation of the Infertile

Infertility is culturally understood as an issue of major concern, particularly for women (supra: 19-27). Pregnancy is something that one expects that they can do without problems and when this does not happen it is understood as unbearable. Women's sacrifices and willingness to use ARTs in order to become mothers is given as evidence, "...that they should be mothers and that motherhood is important" (Ikemoto, 1996: 1040). On *The Oprah Show* Jennifer West describes her inability to bear a child in terms that reflect these cultural expectations:

> It's horrible. It's excruciating. I think so many of us are taught, as kids by our parents, that you can do anything you set your mind to...and anything if you work at it, hard enough if you put in enough effort and time and, you know, thought and consideration, you'll be able to do it...And infertility is completely different (2008: 2.).

Upon discovering her infertility, Jennifer understands her experience as negative and as unnatural (Ikemoto, 1996: 1033). This ideology is reinforced further in the public discourse on Westerners hiring Indian gestational surrogate mothers, "[a] person with infertility only knows the pain of not having a child" (R.S. Sharma quoted in Sharma, A., 2008: 2). Warner writes, "[b]eing infertile when you deeply desire a baby is one of those

heartbreaking, life-altering trials that an outsider to the experience cannot begin to appreciate" (2008: 3). On *The Oprah Show* it is made clear that Jennifer and her husband Kendall are desperate to have a child. The show notes that Kendall and Jennifer tried to get pregnant for three years and Jennifer notes, "...we probably spent about $25, 000 or $30, 000. And it was, basically, everything we had saved up" (2008: 1). For another American woman who was unable to carry a child of her own, "[n]ot being able to have a baby with him [her husband] tormented her" (Haworth, 2008: 2).

Because of their internalization of these societal norms they have come to believe that they are only 'complete' and they are only a 'family' once they have a genetically related child (supra: 14-15). In her *Marie Claire* article Haworth writes, "Ordenes hoped for at least one child with David" (Haworth, 2008: 2) which according to Ordenes is needed "to make our union complete (Jessica Ordenes quoted in Haworth, 2008: 2).

The naturalization of reproduction and feelings of desperation coupled with social familial norms fuel infertile couples to go to extremes to produce genetically related offspring, "Jennifer West and her husband, Kendall, say they were so determined that, three months ago, they went halfway around the world and they hired a total stranger to try and help them have a baby" (Oprah Winfrey, *The Oprah Show* 2008: 1). However, the strength and naturalness of the desire to have children also presents this extreme as a reasonable solution to one's infertility.

India is a place where those Western couples with fewer financial resources can go to 'cure' their infertility. Thus for the infertile who are socially understood and understand themselves as being in pain and suffering and having the right to have a child,

gestational surrogacy and Indian gestational surrogacy has come to be their answer, their cure.

Indian Poverty

Indian gestational surrogate mothers are also depicted as desperate. These women, however, are understood as desperate for a better financial future. India continues to have a high poverty rate, despite its growing middle class. Popularly, however, the focus is on the high poverty rate: "[t]he reality is that hundreds of millions of people still live in the most destitute poverty" (Lisa Ling, *The Oprah Show* 2008: 1). Indian gestational surrogate mothers are most often described as living in poverty and in very poor living conditions, in drastic contrast to the women and couples who hire them, "[t]his was "Julie," an American thirty something who'd come to India to pay a poor village woman to bear her baby" (Warner, 2008: 1). Thus they are understood as being in a position of less socio-economic power than the foreigners who hire them. According to one article, "[i]t's a regular day in his [Dr. Gupta] packed and humming clinic, where poor women in bright saris and tribal jewelry wait beside women whose vast Louis Vuitton hand bags spill over the sides of their chairs" (Nolen(a), 2009: 1). Here the hierarchy is made clear: wealthy foreign couples with sufficient social and financial power to go to a foreign destination to hire gestational surrogacy services, are pitted against the poor Indian women who appear, in contrast, as powerless. These impoverished Indian women are understood as desperate for money, "[a] surrogate in Anand used the money to buy a heart operation for her son. Another raised a dowry for her daughter" (Goodman, 2008: 2). Some want to use the money they can make from

being gestational surrogates to provide a better future for their children, "[m]y daughter wants to be a teacher,...I'll do anything to give her that opportunity" (Najima Vohra quoted in Haworth, 2008: 2).

Some see Indian women's desperate need for money as resulting in exploitation, others feel that the money these women are able to earn by acting as a gestational surrogate mother can be empowering for these women since they will be able to create a better financial future for themselves and their families (Haworth, 2008: 3). The financial gain Indian gestational surrogates receive from Western commissioning couples is understood as positive for the surrogate mothers and thus, it can be understood as a means by which Westerners are helping Indian gestational surrogate mothers. Thus, it can be understood as altruistic for Westerners to provide Indian gestational surrogate mothers an opportunity for a better life. Similarly, the motivations of the Indian gestational surrogate mothers can be understood as altruistic. In India, motherhood is an extremely important role for a woman (Widge, undated(a): 61). To be a mother is to be given respect and power, however, while the "mother goddess" is highly respected, the real life mother has only limited respect and this is usually reserved for the women who are mothers of sons (Widge, undated(a): 62). Motherhood is a means by which an individual woman creates security in her marriage (Widge, undated(a): 62). Infertility in India can be understood as, "... a life crisis with invisible loss" (Widge, undated(b): 68). There are severe social consequences for childlessness, particularly for women, which include rude comments from others (Widge, undated(a): 65), marital and psychological instability, loss of outside relationships with friends and family, (Widge, undated(a): 66),

family disharmony and domestic violence (Widge, undated(a): 67). Thus infertility has a significant impact on the lives of Indian women who have been unable to conceive a child. The undesirability of infertility for women in India is then, perhaps one of the reasons some agree to be gestational surrogate mothers for Western women.

Hopes and Miracles

ARTs have come to be understood as providing renewed hope for infertile couples (supra: 30-31). Because infertile couples have come to understand themselves as virtually 'hopeless', as they feel they have exhausted their other possibilities, particularly their financial means, India has come to provide a new hope for the infertile, "...Lisa shows us what goes on at the clinic that's giving infertile couples around the world, like the Wests here, new hope" (Oprah Winfrey, *The Oprah Show* 2008: 3). Later on in *The Oprah Show*, Lisa Ling announces, "[w]alking into Dr. Nayna Patel's bustling clinic, it's hard to imagine that this tiny building is becoming the world's cradle for people hoping to have a baby" (2008: 3).

Being able to hire a gestational surrogate in India who will and can successfully carry a child for a foreign commissioning couple has come to be represented as part of series of miraculous events. When describing how she received the news that her Indian gestational surrogate mother successfully conceived (via email) Jennifer West says,

> [a]nd so we sat down by the screen together, you know, and the headline, of course, didn't have any information so we opened it and we saw the word congratulations, so –we've been waiting a long time to for that word...Yeah,

> we basically collapsed in each other's arms. It was pretty amazing (*The Oprah Show* 2008: 7).

Upon returning to India with Lisa Ling, while in the ultrasound room looking at the ultrasound of 'her' Indian gestational surrogate mother, Jennifer says, "I'm feeling overwhelmed". This is followed by Dr. Nayna Patel saying, "[s]o now here we have—this is Jennifer, your baby, yes?" [Jennifer responds]

> Yes, beautiful...Oh my gosh. I just – I'm amazed. And only eight weeks, oh, my gosh. I just feel in awe. I waited a long time for this, so it's really exciting It's – it's a miracle. You know, I'm thanking God. I'm just so excited and I wish my husband could be here to hear it (*The Oprah Show,* 2008: 8 - 9).

Thus for those wishing to hire a gestational surrogate mother, India has become a place where miracles are performed, where something seen as unachievable actually occurs. Hence, India is understood as providing new hope to the infertile.

Globalization

Historically less wealthy nations have sold their resources to wealthier nations. This has been well documented in terms of commodities such as coffee, sugar and fruit. In our contemporary society the world is becoming increasingly globalized. According to Gupta, "[g]lobalization is a process that is changing the nature of human interaction across a wide range of spheres (economic, political, socio-cultural, etc.)" (2006: 29). Globalization reinforces and furthers world wide power relations, such as those begun in the sale of commodities.

Globalization is represented as a cause for the development of Indian gestational surrogate services. This newest availability of Indian gestational surrogacy services is understood as the"...globalization of baby-making" (Goodman, 2008:1) developing out of world-wide economic inequality. With particular relation to India's growing economy some understand their growing reproductive tourist industry as,"... a logical outgrowth of India's fast-paced economic growth and liberalization of the last 15 years, a perfect meeting of supply and demand in a globalized marketplace" (Chu, 2006: 1). Thus, India is being presented as "The Cradle of the World" (Goodman, 2008: 1).

While part of the reason for the international reproductive services available in India can be accounted for by the realization of the Indian locals who observed this potential market and have 'opened up shop', the internet also appears to play an important role. On the internet these clinics (as well as other infertility clinics with various specializations worldwide) find a space to advertise their clinics and make it easy for foreigners to find these clinics in India, "[p]rospective foreign clients hear of Patel through world of mouth or informal online networks and websites dealing with infertility issues" (Chu, 2006: 2). Chu also reports, "[i]t can also be detected on the Internet, where a young Indian woman recently posted an ad on a help-wanted website offering to carry a child for an expatriate Indian couple" (2006: 1).

In addition, other web sites have also taken part in 'helping' foreigners find Indian surrogacy clinics by acting as intermediaries and as forums for couples. A simple google search of "Indian Fertility Clinics" and "Gestational Surrogacy in India" produces search results of thousands of articles, clinic websites, such as The Malpani Infertility

Clinic[11], The Akanksha Infertility Clinic[12] and Rotunda – The Center for Human Reproduction[13] and intermediaries such as the Medical Tourism Corporation[14]. Jennifer and Kendall West used the internet to find an Indian fertility clinic that offers Indian surrogacy services to foreign couples, "[t]hat's when Jennifer saw a story online and found out that Anand, India was a place that she could go to hire a surrogate for a fraction of the cost" (Lisa Ling, *The Oprah Show,* 2008: 1). Thus the role of the internet in the context of a globalized world has worked to open up reproductive possibilities on an international scale.

Not only has reproduction come to exist in the context of globalization, but ethical and moral views surrounding the topic have also become ones that are beginning to be globalized,

> [s]o, these borders we are crossing are not just geographical ones. They are ethical ones. Today the global economy sends everyone in search of the cheaper deal as if that were the single common good. But in the biological search, humanity is sacrificed to the economy and the person becomes the product. And, step by step, we come to a stunning place in our ancient creation story. It's called the market place (Goodman, 2008: 2).

Underlying concerns such as the naturalization of reproduction, desperation, renewed hope and globalization have all played an important role in the representation of the

[11] www.ivfindia.com/
[12] www.ivfcharotar.com
[13] www.iwannagetpregnant.com/default.asp
[14] www.medicaltourismco.com; Google last searched Monday June 22, 2009

development of reproductive tourism and particularly in the specific case of Indian gestational surrogate mothers being hired by foreigners.

India: The Ideal Gestational Surrogacy Destination

India has come to be 'the place' to go to hire a gestational surrogate mother. India has been promoted as a place that makes it easier for commissioning couples to hire a gestational surrogate. Not only does India have a large English speaking population and high quality medical care for those who are willing and can afford to pay for it, but it has also been depicted as a last resort destination. Indian gestational surrogacy agreements have been presented as reciprocal help and as an altruistic act. Other factors helping to make India the 'ideal' gestational surrogacy destination include cost, the Indian government and Indian legal stances, the Indian presentation of the Indian gestational surrogate mother's fetus as not her own and the presumed large supply of available Indian gestational surrogate mothers.

A Last Resort

India has come to be understood as a last resort destination for those who wish to choose the option of gestational surrogacy in order to obtain a 'child of their own'. While the availability and the legality of paid gestational surrogacy services varies between the states of the United States, some countries such as Canada and the United Kingdom have placed an outright ban on paying a gestational surrogate mother to carry a child (supra: 61-65). This makes it increasingly difficult to find a gestational surrogate as it appears that most women do not want to act as a gestational surrogate without financial compensation. Furthermore, hiring an Indian gestational surrogate mother is a more

affordable option for Western couples. Reports suggest that surrogacy in the United States can cost upwards of $80,000 U.S. plus (Warner, 2008: 1). However, the price tag for Indian women is much less with suggestions of the total procedure costing around $12,000 (Haworth, 2008:1).

Using the services of Indian gestational surrogates is presented as an absolute final resort and as a last chance for the infertile of having a genetically related child, "I was running out of eggs, running out of hope, and running out of patience with being treated like a number in the U.S. system,...I read about this clinic online – I felt India was my last chance" (Jessica Ordenes quoted in Haworth, 2008: 2). Thus on a global scale India has come to be understood as, "...the salvation destination..." (Nolen, 2009(a): 1).

Helping and Altruism

Indian gestational surrogate mothers are presented as helping the infertile and those who cannot have a child 'of their own' independently of medical intervention, "[c]rushed after multiple failed attempts and thousands of dollars spent, they decided to seek help from a surrogate halfway around the world" (Oprah Winfrey, *The Oprah Show*, 2008: 12). The presentation of India as a last resort destination has helped to promote altruistic ideals. Since it is understood that India is a last resort, the altruistic aspect of the work the gestational surrogate mothers performs is important. On *The Oprah Show,* Jennifer West says, "[y]ou know, I'm so thankful, obviously, for what she's done ..." (2008: 10).

The Indian gestational surrogates are told, and according to some quoted in the news articles feel, that they are helping an unfortunate couple in an immense way. In one article, the author quotes the commissioning mother, Jessica Ordenes, as saying "[y]ou're my angle, you're my angel" (Jessica Ordenes to Vohra quoted in Haworth, 2008: 1), to her Indian gestational surrogate mother, Vohra. One gestational surrogate is quoted as saying, "I'll be happy because they'll be blessed with a child" (Smita Pandy, an Indian gestational surrogate mother quoted in Chu, 2006: 3). Yet another gestational surrogate explains, "[b]eyond the money, she said, there is the reward of bringing happiness to a childless couple in the United States, where such a service would cost them thousands of dollars more, not to mention the potential legal hassles" (Saroj Mehli quoted in Chu, 2006: 1). Since fertility is also very important in Indian society (Widge, undated (a): 61-63) it can be said that their own understanding of infertility can lead to a sympathetic view for those infertile Western couples thereby appealing to altruistic ideals of the Indian gestational surrogate mothers.

However, the ideal of helping is not only for the gestational surrogate mother. Importantly, many media accounts as well as Western couples who use Indian gestational surrogate mothers argue that the commissioning couples also are helping. Such representations work toward attempting to downplay the dominant power relationship between Western women and Indian women and to create a more equalized view of their access to power. Since the women who are being commissioned as gestational surrogate mothers in India are, until recently, almost exclusively those living an impoverished lifestyle, the money they are paid is presented as a life changing amount. Thus, such

accounts justify the hiring of Indian gestational surrogate mothers by foreign couples as a means of helping the Indian women provide a brighter financial future for themselves and their families. Hence, in India, acting as a gestational surrogate mother has increasingly become an important livelihood for those impoverished women. In one instance the Indian gestational surrogate was able to use the money she earned as a gestational surrogate mother to pay for her husband's medical treatment (Surrogacy is no business, 2009). Other media accounts also reiterate this notion of helping:

> Well, Dr. Patel ensures that they make 5,000 US dollars, and it's astronomical. I mean, this amount of money, literally, transforms a woman and her family's lives. And they say that it would take a lifetime to make that amount of money (Lisa Ling, *The Oprah Show,* 2008: 5).
>
> They could not even think of imagining they could have this type of money in their lifetime (Dr. Nayna Patel, *The Oprah Show,* 2008: 14).
>
> For the surrogacy, these women make more money than they could have ever imagined. And it's almost like winning the lottery (Lisa Ling, *The Oprah Show,* 2008:15).
>
> So, it does. It changes the lives of the women who have the opportunity to carry the babies (Oprah Winfrey, *The Oprah Show,* 2008: 16).

Acting as a gestational surrogate mother for a Western couple is presented as helping these particular Indian women to build a stronger financial future in which they can pay off debt, buy/build/upgrade a house or even send their children to school,

So this woman has two kids and her dream, if this works well, is to educate her kids and build a home for them (Lisa Ling, *The Oprah Show*, 2008: 4).

For Pushpa, this is the kitchen she's always dreamed of...Everything is new according to the way she wanted. Earlier she didn't have a kitchen at all (Interpreter, *The Oprah Show* 2008: 15).

For some, this is understood as globalized exploitation (to be discussed). However, others argue against the idea that it is exploitive, believing instead that this provides a great opportunity for women to help their families build a brighter financial future. One Indian gestational surrogate mother argues, "[t]his is not exploitation. Crushing glass for 15 hours a day is exploitation. The baby's parents have given me a chance to make good marriages for my daughters. That's a big weight off my mind (Sofia Vohra quoted in Haworth, 2008: 4). According to Lisa Ling, Dr. Nayna Patel agrees that this is not exploitive, "[w]ell, she [Dr. Patel] says absolutely not" (*The Oprah Show,* 2008: 6).

The use of Indian gestational surrogate mothers by Western couples is also presented as women helping women on an international scale, "[t]here's nothing wrong with this ... We give them a baby and they give us much-needed money. Its good for them and for us" (Priyanka Sharma quoted in Warner, 2008: 2). Television shows such as *The Oprah Show* have constructed this as 'women helping women' and focus on the 'greatness' of the situation, while down playing concerns of international exploitation.

Jennifer, there are a lot of people who are watching this and saying, yet again people with money are taking advantage of poor people. How do you respond to

> that? [Lisa Ling] What I would say to those people is, who are you to judge? You have not walked in my shoes as someone who cannot have a child, and you don't know how that feels. And you have not walked in her shoes and you don't know how it feels not to be able to pay for your children to go to school, to not be able to afford a decent place to live and take care of your family and to provide for your family. You don't know how that feels. And we were able to come together, she and I, and give each other a life that neither of us could achieve on our own. And I just don't – I don't see what's wrong with that. I don't [Jennifer West] (*The Oprah Show* 2008: 12).

Just after this Oprah notes,

> [a]nd—you know, these women around the world—women around the world are helping other women. I just think that's beautiful. I think that's a beautiful thing (2008: 12).

Hence, here, instead of understanding hiring a woman from a lower socio-economic group to carry a child for the genetically related parents as exploitive, it is presented as women helping women. Discursive representations regarding helping, altruism and as women helping women can be connected to feminist ideals which promote women working together. Such a discursive presentation, then, works to downplay specifically feminist critiques which will be discussed in chapter five. Westerners hiring surrogate mothers are understood as providing life changing financial help for Indian gestational surrogate mothers and their families and in turn the Indian

gestational surrogate mothers are understood as helping these unfortunate Westerners to have a genetically related child and family of their own.

Cost

India is understood as providing a less expensive alternative to the West. India is a place where it is believed that "[e]veryone can afford surrogacy" (Dr. Gupta quoted in Nolen , 2009(a): 2). Media reports provide a lot of specific evidence to support this understanding. For instance, on *The Oprah Show* Jennifer West, an American women who had hired a gestational surrogate mother, said, "...we were looking into surrogacy in the United States, but we just couldn't afford to do it..."(2008: 3). Both Lisa Ling and Oprah rearticulate this issue later in the show noting that, "[i]n the United States, having a baby through surrogacy can cost upwards of $80,000. Jennifer and Kendall West could not afford that, but they discovered surrogates in India could be hired for a lot less, about $12,000" (Oprah Winfrey, *The Oprah Show*, 2008: 6).

Additionally, it is important to note that gestational surrogacy is beginning to be understood as an alternative income source for higher castes of Indian women. For instance one reporter reports, "Mariam, a media professional and the mother of a one-and-a-half-year-old, told doctors that surrogacy was the best option she could think of to keep her family going during the slowdown" (Narayan, 2009: 1). The potential for increasingly educated Indian women acting as gestational surrogate mothers may increase surrogacy costs in India, "[t]his could lead to a steep increase in charges for hiring a surrogate mother. With many upwardly mobile women offering their services,

the demands are huge. One of the mothers kept increasing the rates from Rs 2 lakh to Rs 4 lakh" ('Dr. Kamala Selvaraj quoted in Narayan, 2009: 1)

However, since Indian gestational surrogacy tourism has come to be understood as comparatively affordable, middle class Western couples see this as an opportunity that they would otherwise not have. Thus this makes gestational surrogacy available for the middle class Westerners and it is no longer simply for the wealthy.

Government and Legal Concerns

The Indian government has come to promote India as a destination for medical tourism (Gentleman, 2008: 2) including infertility treatments such as gestational surrogacy. However, not everyone agrees that this is in the best interest of the country as it raises a number of moral, ethical and legal concerns (Sharma, 2008, A.: 1).

Legal concerns are yet another reason noted in many news reports as to why India has become an increasingly popular destination for gestational surrogacy services. According to the ICMR, "[t]he contract for surrogacy is legally enforceable" (Ethical Guidelines for Biomedical Research on Human Participants, Director-General, 2006:102). As shown in chapter one the legality of gestational surrogacy worldwide, and the legal connections between a gestational surrogate mother and the eventual child, vary according to jurisdiction (supra: 61-65; Warner, 2008: 2). India allows for gestational surrogates to be financially compensated. The ICMR guidelines, as well as the proposed Assisted Reproductive Technology (Regulation) Bill & Rules, 2008, allow for financial compensation for gestational surrogate mothers. One newspaper article reports, "[i]n India too, the guidelines as well as the proposed Bill makes provision for financial

assistance to the surrogate mother in the form of food, health and business loss" (Sharma, 2008, A.: 1).

As discussed, in many Western countries legal motherhood rights in gestational surrogacy situations are unclear. Warner notes there is, "...little that's clear and conclusive about where a birth mother's rights to a baby end and where the fee-paying mother's rights begin" (Warner, 2008: 2). Additionally in many Western countries, commissioning couples may believe that the gestational surrogate mother maintains legal parental rights to the child regardless of the fact that she is not genetically related to the child, "[t]he legal issues in the United States are complicated, having to do with that the surrogate mother still has legal rights to that child until they sign over their parental rights at the time of the delivery" ("Julie" quoted in Warner, 2008: 1)[15]. The possibility of the gestational surrogate mother keeping or fighting to keep the resulting child is a great fear for those infertile couples who feel that gestational surrogacy is their last opportunity to have a genetically related child.

India, on the other hand, is represented as having fewer legal-strictures, thus making it a more ideal destination for infertile couples wanting to choose gestational surrogacy. It is widely noted that, "India is one of the world's leading destinations for assisted reproduction, and has a booming domestic fertility industry, too, but the country has no laws governing any fertility practices" (Nolen, 2009 (b): 1). While India currently has no law making any form of gestational surrogacy illegal, the ICMR does provide clinics with guidelines of how gestational surrogacy cases *should be* handled. News

[15] In California, the parentage relationship has be come clear after the Johnson v. Calvert case.

reports tell the reader that these guidelines are there to aid the gestational surrogacy process. One article reassures the audience that such practices are acceptable in India, "[t]he Chapter III of this guideline [The National Guidelines for Accreditation, Supervision & Regulation of ART Clinics in India, 2005] has recognized surrogacy as a valid mode of bypassing pain of infertility for a couple" (Sharma, A. 2008: 1). Another account attempts to reassure commissioning couples that 'their' child will not be kept by the gestational surrogate mother. Gentleman reports that according the ICMR guidelines, "...surrogate mothers sign away their rights to any children. A surrogate's name is not even on the birth certificate...This eases the process of taking the baby out of the country" (Gentleman, 2008: 2).

Many representations present India as a place where it is legally relatively easy to obtain gestational surrogacy services. Thus even Indian policy, law and potential legislation do not provide Indian women with much power. Under the ICMR guidelines, the Indian gestational surrogate mother is not afforded the right to the child she was commissioned to carry, thus alleviating the concern for the foreign couple that the gestational surrogate mother will legally be able to keep 'their' child. The ICMR guidelines, as well as media representations, appear to convince foreign couples that there are few legal concerns for them.

The Baby Is Not Yours

Not only is the Indian gestational surrogate mother not afforded the right to keep the commissioned child, but also the child of the Indian gestational surrogate mother is socially constructed as not belonging to the Indian gestational surrogate mother. Clinics

where these Indian gestational surrogate mothers are 'employed' work towards creating a disconnection particularly between the gestational surrogate mother and the child. Popular discourse on the subject suggests that the gestational surrogate mothers are encouraged and taught not to think of the child that they are carrying as their own, and that this may be working. On *The Oprah Show* Lisa Ling notes, "[y]ou know, here in the United States, when people choose surrogacy they're always afraid that the woman carrying the baby might eventually establish those kinds of attachment issues, but they try and prevent that from happening in India" (2008: 10). While American fertility clinics also attempt to keep an emotional distance between the gestational surrogate mother and the baby, India is understood as doing a better job of creating an emotional distance.

Following the ICMR ethical guidelines on gestational surrogacy, Indian fertility clinics ensure that contracting mother/parents are to be considered the legal parents, again supporting the social fact that Westerners have more power. According to the ICMR ethical guidelines, "[t]he intending parents should have a preferential right to adopt the child subject to six week's postpartum delay for necessary maternal consent" (Ethical Guidelines for Biomedical Research on Human Participants, Director General, 2006: 102). Furthermore, the ICMR notes that,

> Genetic parent's claim for the custody for the child in its [sic] the best interest through adoption would be, to establish that the child is theirs through genetic (DNA) fingerprinting, of which the records will be maintained in the clinic (Ethical Guidelines for Biomedical Research on Human Participants, Director General, 2006: 102).

Thus the clinics focus on reiterating to Indian gestating surrogate mothers that the children they are carrying are not 'theirs' but rather the children of contracting parent[s]:

> [i]n Anand, volunteers are repeatedly reminded by Patel and her staff that the fetuses in their wombs are not theirs...No problems have arisen yet with too strong a bond forming between surrogate and child, Patel said (Chu, 2006: 2).

> [c]ounseling is a major part of the process and Patel tells the women to think of the pregnancy as "someone's child comes to stay at your place for nine months (Dolnick, 2007: 3).

Part of this disconnection between the gestational surrogate mother and the child she carries is based in perceptions of genetic connection as connections that define parent-child relationships. Since the gestational surrogate mother has no genetic connection to the baby she carries, she can disconnect herself from the mothering role as genetics are often understood as defining relatedness (Ragoné, 2000: 64-69),"[o]n the other side, surrogate mothers, who are rarely implanted with their own eggs any longer, can believe that the child they bear and deliver is not really theirs" (Goodman, 2008: 2). Some clinics further enforce a disconnection between the gestational surrogate mother, the baby she carries and the commissioning parent(s) as an attempt at keeping the gestational surrogate mother from forming a bond with the child, "[t]he clinic, known more formally as Rotunda – The Center for Human Reproduction, does not permit contact between egg donor, surrogate mother or future parents" (Gentleman, 2008: 1). The goal of this is to prevent the Indian gestational surrogate mother from wanting to claim legal rights to the child.

Some reports indicate that the social construction of the baby as not belonging to the Indian gestational surrogate mother has come to be accepted and internalized by Indian gestational surrogate mothers. Dolnick notes that, "Kailas Gheewala, 25, said she doesn't think of the pregnancy as her own" (2007: 3). She says,"[t]he fetus is theirs, so I'm not sad to give it back...The child will go to the U.S. and lead a better life and I'll be happy" (Kailas Gheewala quoted in Dolnick, 2007: 3). Such comments suggest that Indian gestational surrogate mothers are not bonding with the children they are carrying for foreign couples and they are happy to give the children 'back' to commissioning parents.

Such discourse represents Indian gestational surrogates mothers as less likely to want/fight to keep the child she carried. Since this is a great fear for many couples, this has come to be understood as another benefit of using Indian gestational surrogate mothers and this helps India to be understood as an 'easier' or 'safer' place to go with regards to gestational surrogacy services.

Supply of Surrogates

India has come to be understood as a place where it is relatively easy to obtain the services of a gestational surrogate mother. India is understood as having a larger 'supply' of potential gestational surrogate mothers,"[i]n the last three months, women's hospitals and fertility centres have been flooded with calls from young women offering services for surrogacy and egg (oocytes) donation" (Narayan, 2009: 1). Another article reports, "[y]oung women are flocking to the clinic to sign up for the list" (Dolnick, 2007: 2). Thus such representations lead the reader to the understanding that gestational surrogate

mothers in India are easy to obtain as there are many Indian women willing take on this role.

While some argue the Indian women are willing to act as gestational surrogates for altruistic and cultural factors in India, this willingness is most often understood to be a result of the potential surrogate' ability to earn money from carrying a baby for another person,

> She [Dr. Patel] acknowledged that money was the primary reason these women had queued up to be surrogates; without it, the list would be short, if not nonexistent...But Patel cited cultural components as well- empathy with the childless here in a society that views producing progeny as an almost sacred obligation, and Hindu teachings about being rewarded in the next life for good deeds performed in this one (Chu, 2006: 2-3).

Since Indian women are allowed to be financially compensated for their services, this increases the supply of gestational surrogate mothers. India has a high poverty rate and thus potentially more people than many Western countries who are in need of additional money, "[b]ut India is the leader in making it a viable industry rather than a rare fertility treatment. Experts say it could take off for the same reasons outsourcing in other industries has been successful: a wide labor pool working for relatively low rates" (Dolnick, 2007: 2). It appears that acting as a gestational surrogate mother has come to be understood as a means to make a substantial amount of money in a comparatively short period of time. This reported increase in the number of women willing to act as gestational surrogate mothers for pay creates an atmosphere in which commissioning

couples understand there to be an 'unlimited' supply of willing gestational surrogate mothers. This ability to pay a gestational surrogate mother without legal hassle and the presentation of a 'limitless' supply of inexpensive gestational surrogate mothers has worked to increase the popularity of these services for Western individuals.

In my examination of newspaper articles, magazines and websites I found that India is described as 'the place' to go for gestational surrogacy. Media representations of the use of Indian gestational surrogate mothers by Western couples represent India as a last resort destination. The discourse also characterizes this phenomenon as one of helping and altruistic ideals. India has come to be understood as a less expensive alternative to Western countries with respect to gestational surrogacy. Indian government and legal presentations suggest India is a place where there is less 'red tape' surrounding this issue. Both the ICMR and individual fertility clinics work to promote the ideal that the Indian gestational surrogate mother has no rights to the non-genetically related child she carries. Finally, India has come to be understood as a country with high rates of poverty and gestational surrogacy is presented as a viable alternative. This has led to the belief that there is a large supply of Indian gestational surrogate mothers. All of these media representations work together to create an understanding of India as the ideal destination for those foreigners who wish to opt for gestational surrogacy as a means of genetic reproduction.

Conclusion

Generally, Indian gestational surrogate mothers occupy a position of less power in relation to those hiring their services. Indian gestational surrogate mothers are

characterized and understood as impoverished, desperate women who, while they acknowledge helping and altruistic ideals, can be understood as acting as gestational surrogates in order to create a brighter financial future both for themselves and their families. Those using their services are also depicted as desperate, however, they are desperate to have a genetically related child, which they are unable to achieve the 'natural' way. As discussed earlier, dominant representations of commissioning couples are of those who are white, comparatively well educated and financially secure Westerners. However, some representations do include individuals who are Japanese, Israeli and Nigerian. Not all individuals have equal access to the services of the Indian gestational surrogate mothers as both monetary access and social access is restricted. Such individuals are those in positions of less social power such as those who cannot financially afford fertility services and homosexuals.

Underlying ideologies of the naturalization of reproduction and presentations of hope and globalization can be understood as having great affect in the development of reproductive tourism as it relates to India. Furthermore, specific representations including India as a last resort destination, price concerns and government and legal issues work to promote India as a popular destination for fertility tourists. The particular focus Indian fertility clinics and the ICMR regulations place on presenting the fetus a gestational surrogate mother carries as not her own and the social understanding of a large supply of Indian gestational surrogate mothers have also proven to be factors which have defined India as 'the place' to go with respect to gestational surrogacy.

The following chapter examines the 'against', more critical, side of the ethical master narrative of Indian gestational surrogacy. It will be shown that concerns around defining nationality and changing family structures, exploitation and the understanding of Indian gestational surrogacy as a business which commodifies the human body are all dominant competing discourses surrounding Indian gestational surrogacy. Furthermore, the 'against' ethical concerns regarding the dehumanization of Indian gestational surrogate mothers (including issues of choice, a focus on fetal rights and the monitoring of Indian gestational surrogate mothers) also proves to be important to the creation of the master narrative of Indian gestational surrogacy as an ethical debate.

Chapter Four Analysis:

Indian Gestational Surrogacy Tourism: Raising Concerns

Equally important to the more positive representations of Indian gestational surrogacy tourism discussed in chapter three are the critiques of Indian gestational surrogacy tourism. Not all representations of Indian women being hired by those comparatively wealthy Western couples are positive. In fact, there are many critiques of what is often referred to as "wombs for rent". Many media representations understand this issue as yet another example of worldwide economic inequality with people from wealthy nations exploiting people in less developed countries. This chapter moves on to examine the critical side of the master narrative of Indian gestational surrogacy tourism. Concerns include issues of nationality and the reconstruction of family structures, exploitation and the development of a gestational surrogacy business which commodifies human bodies. Dehumanization, including issues of choice, a focus on the fetus over the gestating Indian surrogate mother and the monitoring of the Indian gestational surrogate mothers, is also examined.

Legal Concerns, Issues of Nationality and New Formation of Family

As discussed earlier, many representations of India as the ideal gestational surrogacy tourist destination present India as a place with few legal concerns. However, there are also recent representations showing the legal problems related to Indian gestational surrogacy tourism. Recently, there has been an attempt to pass legislation regulating this industry. One particular case, known as the "Baby Manji" case, has brought foreign gestational surrogacy to the front lines and has been cited as the reason

for the need for legislation governing this area. In contrast to the *Johnson vs. Calvert* case in California where the gestational surrogate mother was fighting to keep the resulting child, in the Baby Manji case the legal concern focuses on problematic parentage and adoption legislation. Baby Manji Yamada was born to an Indian gestational surrogate mother who was hired by a Japanese couple, Ikufumi and Yuki Yamada (Baby Blues, 2008: 1). The egg, however, was not from Yuki, the commissioning mother, but rather an egg donor (Bhandari(b), 2008). After the gestational surrogate mother had been implanted with the embryo the couple dissolved their relationship. While the biological father, Ikufumi, wanted custody of baby Manji, Yuki (the commissioning mother) as well as the egg donating mother and the gestational surrogate mother were all reported as not wanting to have any relationship with baby Manji. Thus began an intense debate as to who baby Manji's mother is. To complicate the situation further, the father, "...is unable to do so [take custody of baby Manji] because Indian law does not permit a single male to adopt a girl child" (Baby Blues, 2008: 1). After a long legal battle, baby Manji was finally given a one year visa to go to Japan in the care of her grandmother to be with her father (Finally, baby Manji flies, 2008: 1). However, this is only a temporary solution. This particular situation, then, is one which is cited as showing that there is need for legislation governing foreign surrogacy in India, "[s]ituations such as Japanese baby Manji's plight – her parents broke up and her surrogate mother doesn't want her-can henceforth be avoided" (Iyer, 2008: 1).

Due to the growing business of gestational surrogacy in India, and out of reaction to complications that have arisen, such as the baby Manji case, a bill has been proposed

in India to officially regulate gestational surrogacy as well as other forms of ARTs. However, there is not yet social agreement as to whether or not the legislation would be useful, "[w]hile many fear the new rules-along with the mountainous paperwork-will only increase costs, an equal number feel that the new laws protect all the parties involved, from the parents and surrogate women to the child and the doctors" (Iyer, 2008: 1). Those in favour of the bill argue that it is an attempt at better regulation and protection for all parties involved in the gestational surrogacy process, "[i]n India, there is no law to regulate surrogacy and the government now wants to fill this void to avoid exploitation of the parties involved (Surrogacy is no business, 2009). The new law will ensure that all foreigners with the intent to use Indian gestational surrogate mothers in India will, "...first have to register with their embassy...The foreign couple will also state whom the child should be entrusted to (which set of grandparents, for instance) in case of an eventuality such as a genetic parent's death" (Iyer, 2008: 1). However, Iyer reports that safety for the Indian gestational surrogate mother is of key importance (2008: 1), "[e]verything will be in contract form. Surrogate mothers will have an insurance cover paid for by the parents-to-be in case of an adverse outcome," (Dr. Gautam Allahabadia quoted in Iyer, 2008: 1). Dr. Gautam also points out that, should all the proposed bill become law, "[a]ll the grey zones in infertility treatment have become black and white," (Iyer, 2008: 1).

Concerns have been raised in the discourse with regards to the nationality of children born out of Indian gestational surrogacy arrangements as well as with respect to the development of new family formations. For instance, in the baby Manji case, there

was concern for the fact that baby Manji was potentially technically orphaned, "[i]f the baby, whose nationality is Indian, doesn't get an Indian passport after the adoption process is completed, she may become the country's first surrogate-orphan" (Bhandari(a), 2008). After a legal debate, Manji was awarded an Indian Identity certificate which would allow her to travel to Japan to be with her father (Bhandari(d), 2009). However, Manji was issued only a Japanese visa and not citizenship (Finally, baby Manji flies, 2008). Manji's nationality remains unknown.

In another case a British couple, Chris and Susan Morrison, traveled to India to hire a gestational surrogate mother, resulting in twins. Nationality of the twins (Louis and Freya) became uncertain, "...the UK regarded the twins as Vilma's children [the Indian gestational surrogate mother], while India recognized them as the Morrisons'" (Bhatia(c), 2009:1). After weeks of being forced to stay in India with their children, the issue was finally resolved, "[t]he couple had to apply for British passports then Indian exit visas..." (Bhatia(c), 2009:1). Thus, without clear guidelines, resolving a child's nationality can become problematic for foreigners.

New family structures are also an issue with both the baby Manji and Morrison examples. In the baby Manji case, none of the potential mothers wanted to claim Manji as their own. Feminist understandings of motherhood vary, however, such lack of desire for motherhood by these women can perhaps be understood as women acting against historical hierarchical and power structures, thus refusing to define themselves as mothers. Only Manji's paternal grandmother was willing to accept the child in the mothering role. With respect to the Morrisons, both the United Kindom and Indian

understood 'foreign' women as the mother. Who then do we consider to be baby Manji's or the British twins' mothers? Determinations of motherhood have been further complicated by conflicting laws between India and the United Kingdom. These legal complications introduce uncertainty into gestational surrogacy services available to foreigners and are contradictory to claims of the ease of use of Indian gestational surrogacy services.

Another issue is with respect to the Indian gestational surrogate mother's continuing social connection to the child. While India makes it clear that the Indian gestational surrogate mother is not to be considered the legal mother of the resulting surrogate child, some commissioning couples keep in touch with the Indian gestational surrogate mother and in some ways she becomes a part of the family. For instance, one gestational surrogate, Mandul, is reported as missing the surrogate child she gave birth to but "... she stays in touch with the parents over the Internet [and] A photo of the American couple with the child hangs over the sofa" (Dolnick, 2007: 3). Many feel that in some way the gestational surrogate will forever be a part of their lives, "these are women we don't know, will never know, who will become in a way part of our lives" (Yonatan Gher, quoted in Gentleman, 2008: 4). The gestational surrogates too feel that the child will always part of their lives. On *The Oprah Show*, Sangita, a gestational surrogate mother says through a translator, "[a]nd [sic] the end of it when we give the baby away it is their choice to remember us or not. But we will be remembering the child to the end of our life" (2008: 14). The connection through pregnancy, despite clinics' efforts to encourage gestational surrogate women to see the child as 'unrelated', is not so

easily forgotten. Thus, social questions of how to include or not include the Indian gestational surrogate mother in the family have also arisen.

Exploitation

Another public discourse surrounding gestational surrogacy with respect to India is exploitation (supra: 50-55). Exploitation of women is a common feminist critique of gestational surrogacy both as it relates to Western and Indian gestational surrogate mothers. In her *Marie Claire* article Haworth writes, "[a]nother example of third-world exploitation? Globalization gone mad? The system certainly lends itself to the criticism that foreign women unwilling or unable to pay high Western fees happily exploit poor women at a 10^{th} of the price it would cost back home" (2008: 1). This situation is criticized as taking advantage, particularly financially, (supra: 50-55) of third world women and as yet another example of international exploitation. Feminist concerns with power relations can be seen here. It is, in part, the worldwide hierarchical power structures of the first and third worlds base on financial power that underlines Indian gestational surrogacy tourism. Warner suggests that Western moral views are different when it comes to third world nations such as India. In the United States she notes that, "...lip service has long been paid to the notion that women can't be instrumentalized as baby-making machines" (Warner, 2008: 2). However in dealing with third world countries, Western moral views appear to be weakened,

> ...our rules of decency seem to differ when the women in question are living in abject poverty, half a world away. Then, selling one's body for money is not

> degrading but empowering. And the transaction is not outsourcing at the basest nature…but a good deal for everyone concerned (Warner, 2008: 2).

In these discourses Indian women are understood as being taken advantage of due to their extreme poverty. One *Times of India* author writes,

> [s]urrogacy, an area unregulated till now, meant that childless couples from abroad as well as in the country could get away with renting a womb at terms often to the disadvantage of a needy women who stood the chance of being exploited (Singh, 2007: 1).

This is echoed by Dolnick, "[c]ritics say the couples are exploiting poor women in India – a country with an alarmingly high maternal death rate – by hiring them at a cut-rate cost to undergo the hardship, pain and risks of labor" (2007: 2). Goodman points particularly to economic inequality and to the lack of education these women have as a problematic factor, "[b]ut we rarely see a rich woman become a surrogate for a poor family. Indeed, in Third World countries, some women sign these contracts with a fingerprint because they are illiterate" (2008: 2).

Dominant representations of the body as priceless are also presented within the discourse. Bodily, as well as financial, exploitation of the women involved is also a concern, particularly when one takes into account the potential for physical harm or death during the Indian gestational surrogate mother's pregnancy,

> Others aren't so sure about the moral implications, and are worried about the exploitation of poor women and the risks in a land where 100,000 women die every year as a result of pregnancy and childbirth. Rich couples from the West

paying Indian women for the use of their bodies, they say, is distasteful at best, unconscionable at worst (Chu, 2006: 1-2).

Others are concerned that this type of exploitation of the Indian women in the absence of any regulating legislation has led to corruption of those running the business which further exploits poor and undereducated Indian women:

> The sensitive issue of surrogacy in the absence of laws and regulations has been a free playing field for unscrupulous intermediaries who lure and push uneducated and poor women into surrogate motherhood (unknown WCD ministry official quoted in Singh, 2007: 1).

Many representations position Indian gestational surrogacy use by Westerners as financially and physically exploitive on an international scale. This exploitation can be understood as a result of the development of Indian gestational surrogacy into a business which commodifies human bodies.

Business and the Commodification of the Body

Not only do many feel that Westerners using Indian gestational surrogate mothers is exploitive, but many also understand gestational surrogacy overall as a business which commodifies the human body. Indian gestational surrogacy services have become a reproductive tourist business, "[t]here is growing evidence that surrogacy is very much in practice in India and that the services of women are being marketed for surrogate motherhood" (Sharma,A: 2008: 2). One article notes a particular clinic, The Akanksha Fertility Center, as being "...at the forefront of India's booming trade in so-called

reproductive tourism (Haworth, 2008:1.) India has become a "major destination" with respect to the reproductive tourist business largely due to its competitive prices,

> India is emerging as a major destination for surrogacy a childless couples from US and Europe are lured by the prospect of having a surrogate child for around Rs 100,000 ($2,250) to Rs 225,000 ($5,060) each pregnancy compared with some $40,000 or even more in the US(Singh, 2007:1).

This business appears to follow traditional laws of supply and demand, suggesting that India is in competition with other countries. In the United States, it is suggested, there are relatively few women willing to act as gestational surrogate mothers and therefore it costs more money. In India there is greater supply of willing potential surrogate mothers, driving costs down. According to one author, India's surrogacy business is providing "stiff competition" to the American surrogacy industry (Taylor, 2009:1).

For critics, echoing feminist concerns, this business is one that focuses on commodifying the female body as well as the resulting child. Critics are concerned that gestational surrogacy in India has become an international business which commodifies women's bodies and relies on international exploitation of the World's poor (supra: 50-55). In many discursive representations, this is an unacceptable commercialization of the human body: "[s]ome things we cannot sell no matter how good "the deal"" (Goodman, 2008: 2). Thus the earlier concern with the exploitation and the commodification of women's bodies has come to also be a critique of Indian gestational surrogacy services available to foreigners.

The infertility clinics that provide access to Western couples have helped to transform baby making into a business. However, it is not just presented as a business, but one which is rapidly growing with some estimates suggesting it draws $445-million per year (Warner, 2008: 1). On *The Oprah Show* Lisa Ling notes that at that time there were approximately fifty Indian gestational surrogates working for international couples (2008: 5). On the same show, Dr. Nayna Patel notes that she now has a waiting list with somewhere between 250 to 300 couples waiting to hire an Indian gestational surrogate mother(2008: 3). In *The Times of India,* Nijher reports, "[t]here is so much traffic that doctors are finding it tough to fulfil [sic] the demand" (2008:1). The demand for these services has led to a growing number of fertility clinics offering international reproductive services (Surrogacy is no business, 2009). Here, the industry is seen as growing and it is growing due to consumer demand. Furthermore, in contrast to earlier discussions of a 'limitless supply' of Indian gestational surrogate mothers, large numbers of women are not necessarily 'running' to fertility clinics to become gestational surrogates for pay. While it is a rapidly growing business, there remains a lengthy waiting list for commissioning couples. Thus, it appears that the demand continues to outweigh the supply of gestational surrogate mothers.

Equating Indian women being hired by international couples to the latest form of outsourcing is also common. Often this service is referred to as "wombs for rent" or as "outsourced wombs" (Warner, 2008: 1). No longer are Western businesses simply capitalizing on and outsourcing industries such as the IT industry in India but now they have gone to further exploit uniquely female labour. Chu writes,

> Driven by many of the same factors that have led Western businesses to outsource some of their operations to India in recent years, an increasing number of infertile couples from abroad are coming here in search of women such as Mehli who are willing, in effect, to rent out their wombs (2006).

This description may also be observed in the headline in one *Macleans* article, "Outsourcing life itself: what India Teaches us" (From the Editors, 2007: 1). The body of the same article notes, "[s]urrogate pregnancy in India represents what must surely be the final frontier of offshoring" " (From the Editors, 2007: 1).

Another key business discourse centers on equating the services of Indian gestational surrogate mothers to baby factories or baby farming. One headline in the *Globe and Mail* states, "Desperate mothers fuel India's 'baby factories' (Nolen(a), 2009). For Dr. John Lantos, these services, "...raise[] the factor of baby farms in developing countries...It comes down to questions of voluntariness and risk" (Dolnick, 2007: 2). Again, feminist concerns regarding power relations are present. Such discourse shows that Western couples, and particularly women, maintain power over Indian women, to the extent that it may reduce Indian women to producers in 'baby factories'. Warner also describes these services as a baby factory, "[i]mages of pregnant women lying in rows, or sitting lined up, belly after belly, for medical exams look like industrial outsourcing pushed to a nightmarish extreme" (Warner, 2008: 1). In *The Globe and Mail,* Nolen quotes Nandita Rao, "a lawyer pushing for regulation of the fertility industry" as saying,

> These surrogate mothers are just being kept there like baby factories...The women are just sitting there producing that child with no rights on that child and

no rights on their health... In India, which is so fiercely patriarchal, many families are using their daughters-in-law as baby-churning factories (2009(a): 2).

Here feminist concerns regarding the structural shaping of women's 'choices' are considered. Such a business may take away the personal agency of Indian gestational surrogate mothers, thus placing them in less socially empowering positions.

Another indicator that baby making has become a business is fertility clinics' use of success rates to attract customers. Clinics report and publish these success rates on their websites as a means to compete with one another and as a means to lure potential commissioning couples. Success rates given by the fertility clinics are often considered high. This potentially creates the illusion that one will easily be successful in obtaining a genetically related child through an Indian gestational surrogate mother. On *The Oprah Show* Dr. Nayna Patel of the Akanksha Fertility Clinic reports the previous years success rate as being 44%, which is according to Lisa Ling, "...considered high" (2008: 5). According to Nolen a doctor from another clinic, Dr. Gupta, "...considers himself a sort of Santa Claus figure. He promises the endless stream of anxious women that his success rate is about 50 percent, that they too will have babies" (2009(a): 1). While clinics report the success rates to lure commissioning couples, the use of these rates further the understanding of Indian gestational surrogacy tourism as a business.

Indian gestational surrogacy services, for the women who do the gestational work, appear to be changing from a one-time contract to a 'steady job'. Some representations depict the Indian situation as one in which the role of the Indian gestational surrogate mother is becoming a steady job, "[t]op gynaecologist and associate

director of Fertility Research Centre, G G Hospital, Chennai, Dr. Kamla Selvaraj, on Saturday admitted that surrogacy....is slowly taking the shape of a profession with several women offering their uterus to another woman for monetary compensation" (Jha, 2003). Goodman writes, "[i]n the last few months we've had a full nursery of international stories about surrogate mothers...In turn, there's a new coterie of international workers who are gestating for a living" (2008:1).

As with any career, very specific requirements have arisen to qualify as a gestational surrogate mother in India. According to Dr. Nayna Patel of the Akanksha fertility clinic, "[t]wo out of 10 is the average wherein we have to refuse them [surrogates]. You are not fit, you are over age, and I don't think we can – you can carry the pregnancy and delivery in a proper way" (*The Oprah Show*, 2008: 5). Age is one particular requirement in India for a gestational surrogate mother, "[i]n India, we allow it up to 45 years of age" (Dr. Nayna Patel, *The Oprah Show* 2008 :5) but the gestational surrogate mother must be at least 18 years of age (Dolnick, 2007:3). Indian gestational surrogate mothers have to be in generally good health (Dolnick, 2007: 3). Indian gestational surrogate mothers are required to have children of their own in order to help prevent the gestational surrogate from wanting to keep the resulting child, "Dr. Patel says they have to at least have one living child of their own...She wants to try and ensure that the surrogates don't develop any kind of emotional attachment" (Lisa Ling, *The Oprah Show,* 2008: 10). These requirements must be met in order for an Indian woman to be accepted as a gestational surrogate mother (Lisa Ling on *The Oprah Show* 2008: 7). Thus such 'prequalifications' are not only applied in order to maintain a standard, but are

also presented in media accounts as a means to inform both the foreign couples and the potential Indian gestational surrogates of the requirements. This also works to reassure potential commissioning couples of the 'quality' of the Indian gestational surrogates in order to reassure them that the resulting child will also be of high 'quality'. If the Indian women do not meet these requirements, they are rejected. Thus, such requirements continue to place Indian gestational surrogate mothers in positions of less power.

Representations that present Indian gestational surrogacy as a career illustrate this through noting that Indian women acting as gestational surrogates are doing this for a second and potentially more times (Oprah Winfrey and Lisa Ling, *The Oprah Show*, 2008: 7). Other articles report a similar career-building approach"[a] few have already gone through the process once and are eager for a second go-round" (Chu, 2006: 2).Thus, it is not simply a one time service in order to help gain financial security, but rather a viable 'career' opportunity. Such representations are further archived through reporting that women who have better education are considered to be 'higher up' in their careers as gestational surrogate motherhood, "[m]any of the best-known Infertility clinics offer a roster of surrogate profiles from which to choose. Better educated women command a higher price – perhaps a $7,000 fee, compared to $3,000 for a village woman in Gujarat. The buyer also pays for medical and living costs" (Nolen(a), 2009: 2). Since the discourse notes that these women are potentially acting as gestational surrogate mothers multiple times and that those with better educations tend to earn more money, the discourse further presents Indian gestational surrogacy tourism as a business that supports 'careers' or 'steady jobs'.

Many representations of Indian gestational surrogacy tourism that present it as a business generally understand this in negative terms as can be observed in terms such as "wombs for rent" and "baby factories" and the comparisons made to gestational surrogacy as "outsourcing" reproductive capabilities. Indian gestational surrogate services are represented as a business willing to exploit poor female labour. Success rates of these 'baby factories' act to lure foreign couples seeking gestational surrogacy services. Furthermore, some representations suggest that gestational surrogacy is becoming a viable career option for Indian women.

Dehumanization

Many are concerned at the potential for dehumanizing Indian women in providing international access to Indian gestational surrogacy services, "...[it] feels like a step toward the kind of insane dehumanization that fill the dystopic fantasies of Aldous Huxley's "Brave New World"(Warner, 2008: 1). Issues such as the Indian surrogate mothers' potential lack of choice, the focus on the fetuses over the pregnant women and the control placed on the Indian gestational surrogate mothers' bodies are presented as dehumanizing these women.

Many who disagree with the idea of renting out the human body (Warner, 2008: 2), depict Indian gestational surrogates as objectified body parts. Indian gestational surrogate mothers are often presented as "wombs for rent"(Subramanian, 2007; Scott, 2007; Dolnick, 2007; Chu, 2006; Haworth, 2008; Sharma, A. 2008; *The Asian Pacific Post*, 2006), "wombs for hire" (Nijher, 2008) "outsourced wombs" (*The Oprah Show*, 2008; Warner, 2008), "host[s]" (Warner, 2008), "incubator on legs" (Warner, 2008),

"baby-making machines" (Warner, 2008) and as women who are "loaning [their] womb[s]" (Ramesh, 2006) who work in 'baby factories' (Nolen(a), 2009) or in a "womb business" (Singh, 2007). One husband of an Indian gestational surrogate mother describes his wife as "providing temporary shelter", "[h]er husband looks at it this way: Just as he and his family live in a rented house, his wife's womb is also providing temporary shelter – for a fee – to a child belonging to someone else" (Chu, 2006: 3). Such representations focus only on these women's uteruses and reproductive capabilities, and so these women are only valued for being able to provide their bodies for foreign use.

Choice

Furthermore, like early discourses of gestational surrogacy (supra: 55-58), the discourse on India focuses on the question of whether or not these women are being coerced into it. Some articles question whether or not these women have freely chosen to act as gestational surrogate mothers. Some representations suggest that it is the lack of socio-economic power the Indian gestational surrogate mothers have (they are often poor, they do not feel they have any better options) which pushes them into becoming gestational surrogates (supra: 56), "[a]nd poor Indian women don't have an awful lot of choices so far as real money-making – to pay for school, to pay for a home – is concerned" (Warner, 2008: 3). Another article points out that the alternative to becoming a gestational surrogate mother is no better, "...consider her alternative in Anand: a job in a factory for $25 a month" (Goodman, 2008: 2).

Others depict the potential of coercion from family members, "[t]wo of her sisters have already served as surrogates—one of them for foreigners—and so has her sister-in-law. Mehli finally decided to join in, with the enthusiastic consent of her husband, a barber, and the guidance of a local doctor..." (Chu, 2006: 1). Nolen reports that another Indian gestational surrogate mother, "...the woman, Puja, 21, said quietly that she didn't like the idea and it took her three months to agree, that she gave in because her father-in-law has left the family with debts that they must pay. She has two small children of her own..." (2009(a): 2). Again feminist concerns about unequal power relations are present in these representations. The potential for coercion financially, from family members and other social contacts, can take away the power and agency of Indian gestational surrogates. Indian women who have been coerced into becoming gestational surrogate mothers for pay through financial, familial and social coercion thus lose their power to independently make their own choices, thereby losing personal agency. Losing agency disempowers the Indian gestational surrogates and this works towards their dehumanization.

Fetal Focus and the Monitoring of the Gestational Surrogate Mothers

Another means of dehumanization is presented through the focus on the fetus and the monitoring of Indian gestational surrogate mothers. The understanding of the fetus as more important than Indian gestational surrogate mothers relates to the Western feminist critique of such a paramount focus during pregnancy (Quéniart, 1992). The Indian Women's Protection League has raised concern over the potential adverse affects for the Indian gestational surrogate mothers (Mendick and Bhatia, 2009: 2). Some argue that the

potential new legislation, "... is only trying to make the arrangement safer for surrogate women" (Iyer, 2008: 1). However, while some concern for the Indian gestational surrogate mother is apparent, it appears that the dominant concern is the foreign fetus rather than the gestational surrogate mother. Some consider Indian gestational surrogate mothers easier to control and monitor (Rothman, *Public Hearing on Surrogate Parenting*, 1988: 211 cited in Markens, 2007: 84) because they have few alternatives and may be in desperate need of money. Popular Western understandings of the Hindi and Muslim religions depict Indian women as less likely to be involved with vices such as smoking, drinking and doing drugs (Gentleman, 2008: 2).

General rights of the gestational surrogate mother appear to be subservient to the general rights the fetus and of the commissioning couple. For instance, in one case a gestational surrogate mother was brought to stay with the commissioning couple and was accused of stealing from them. As a result, according to Nolen, the commissioning mother calmly said, "[w]e lost confidence in her, so we terminated the pregnancy," (2009a: 2).[16] Thus, the gestational surrogate was forced to abort the fetus she was carrying in her own body.

Often the medical and health rights of the fetus (and hence the rights of the foreigners') supersede the medical and health rights of the gestational surrogate mother. Indian fertility clinics monitor Indian gestational surrogate mothers more tightly than the same women experienced during their own pregnancies. Not only are these women

[16] Please note that the article was unclear as to whether or not the gestational surrogate mother was Indian or not, however, within the context of the article it appears to make reference to a woman of Indian ethnicity.

monitored with relation to their personal habits, but they are medically monitored to ensure no harm has come to the fetus. One article noted that the Indian gestational surrogate mothers were subjected to "constant monitoring" (Warner, 2008: 2). In order to provide Western couples with a sense of security over the wellbeing of 'their' child, it appears to be understood as acceptable to keep a close watch on Indian gestational surrogate mothers, "...many of the surrogate mothers are showered with gifts of food and medicine and monitored with solicitous attention by the waiting parents, usually educated, sophisticated people who want to ensure that their investment yields its much-hoped-for fruit" (Chu, 2006: 3). On *The Oprah Show* Lisa Ling reports, "[t]hey are monitored 24 hours a day..." (2008: 13). This is also touched upon earlier in the show,

> This is the third floor of the clinic, and the surrogates stay here for 15 days right after the embryo transfer and one month before they have the baby. So if you think about it, they spend most of their time just sort of laying here for that period of time, because this is a big investment and the stakes are high. I mean, these women have staked their whole family's future on this (Lisa Ling, 2008: 4).

While this appears to be meant to reassure the commissioning couples, it is clear that the medical rights of the fetus are put ahead of the medical rights of the Indian gestational surrogate mothers. While it may be understood that 'just sort of laying here' is a good thing for the gestational surrogate mothers in order to protect their 'investment', it is evident that the concern here is ultimately for the surrogate baby. This presents the idea that the Indian gestational surrogate mothers should not be doing much else other than gestating the surrogate child.

Those Indian women acting as gestational surrogate mothers are also given better medical care than when gestating and delivering their own children. For instance one article notes, "Dodia's [a gestational surrogate mother] own three children were delivered at home and she said she never visited a doctor during those pregnancies" (Dolnick, 2007: 3). According to Suman Dodia, "I'm being more careful now than I was with my own pregnancy (Dolnick, 2007: 3). The particular care Indian gestational surrogate mothers take during their commissioned pregnancy is in part a result of knowing their own future is at stake. Should anything go wrong with surrogate pregnancy, they will likely be blamed. In any case (whether or not they are at fault), should the Indian women not produce a live birth from the surrogate pregnancy, they will not be awarded the money they are trying to earn.

While the pregnancies of Indian gestational surrogate mothers are more controlled and monitored by the clinics, the gestational surrogate mother herself is being cared for less. In one case, the Indian gestational surrogate mother had not been informed of a major medical concern with the potential of having very adverse affects on the gestational surrogate mother: she was carrying twins. According to Nolen, "Anita [the commissioning mother] comes to hover over her ultrasounds; asked how Puja [the Indian gestational surrogate mother] felt about carrying the twins developing in her womb, Anita replied blithely, "Oh, we haven't told her yet" (2009(a): 2).

To avoid endangering a gestational surrogate mothers' health and life, many Western countries, like Canada, limit the number of embryos implanted into a women to two (Nolen, 2009(a): 2; the Canadian *Assisted Human Reproduction Act S.C. 2004*).

However, Indian clinics do not appear to give the Indian gestational surrogates the same consideration, "...Dr Gupta's policy is less strict" (Nolen, 2009(a): 2). Dr. Grupta is reported as saying, "[y]ou can get a 40-50 per cent success rate by implanting three or four, and if there are multiple, we reduce the number – if more than two is [not desired]..." (Nolen, 2009(a): 2). Here the Indian gestational surrogate mother is forced into reduction, whether or not she agrees to it, "[i]t is part of the standard Gupta clinic surrogacy contract that a surrogate must terminate a pregnancy if the doctor directs her to do so" (Nolen, 2009(a): 2).

On *The Oprah Show* the focus on the well being of the fetus and goals of the American commissioning couple also appear to take precedence over the well being of the Indian gestational surrogate mother,

> ...she's like the smallest surrogate they have...And—but the doctor insures us that, you know, it's not a problem and the babies are all relatively similar in size. And when I first saw her, we were shocked, but they were so sweet. Her family was great and the doctors ensure us that it'll be good (Kendall West, 2008: 11).

In response to being asked how the child will be delivered Jennifer responds, "C-section probably, so we'll know", referring to the fact that it will likely be a planned delivery so they will know when the birth is occurring (*The Oprah Show,* 2008: 17). Thus the concern is that the Indian gestational surrogate mother may have complications during birth which may affect the baby, but no mention is made of what the risks are for the Indian gestational surrogate mother, particularly in undergoing cesarean section, a major surgery.

Generally, the challenging aspects of the physical and emotional experience of pregnancy and delivery are minimized for the Indian gestational surrogate mother, even by the Indian gestational surrogate mothers themselves,"[s]he [Smita Pandy] doesn't worry about potential ill effects of the pregnancy on her own physical or mental health" (Chu, 2006: 3). This was also briefly touched upon on *The Oprah Show*, "[w]hy are you sad?" [Lisa Ling interviewing an Indian gestational surrogate mother] "[s]he miss, because very small son" [interpreter for surrogate mother] (2008: 5), referring to the fact that she misses her own small son whom she has seen very little as she is staying in one of the boarding houses run by Dr. Patel for gestational surrogate mothers. Later in the show, Lisa Ling asks another Indian gestational surrogate mother,

> Will it be difficult to give the baby away after carrying it for nine months?" She says, definitely. And the end of it when we give the baby away it is their choice to remember us or not. But we will be remembering the child to the end of our life [interpreter for surrogate mother] (2008: 13 -14).

However, the brief discussion of these downfalls presents them as only small sacrifices, thus minimizing the emotional and physical experience of the Indian gestational surrogate mother[17].

The discourses around "risk factors" as affecting only the fetus and not the pregnant woman reflects the discourse around pregnancy and birthgiving in North America, which places the responsibility for the proper development of the baby on the woman carrying the child. The emphasis is placed on how she lives her life and how this

[17] Similar findings have come out of research conducted by Goslinga-Roy, 2000 in the United States of America.

will affect the fetus (Quéniart, 1992: 165). Any question with regards to the "normality" of the child leads to questions about the "normality" of the woman's pregnancy (Quéniart, 1992: 165). Consequently, the focus on risk has come to focus on the fetus rather than the risks associated with the birthing mother (Quéniart, 1992: 163; Markens, 2007: 55). The fetus has come to be understood as the "primary patient" leading to neglect of the birthing mother (Quéniart, 1992: 170-171). While this is presented as reassuring to commissioning couples, the implied total control over an adult woman's body for the sake of the fetus is disturbing. There is a doubled effect on the Indian gestational surrogate mother – she is responsible for someone else's fetus, and the doctor caring for her, unlike the doctor caring for a pregnant woman who will be keeping her baby, has an additional 'client' beyond the pregnant woman and fetus, whose primary concern is that fetus. Thus this focus on the fetus and continual monitoring places the Indian gestational surrogate mother in a subordinate position, almost removing her from the process, hence working to dehumanize her.

While the focus on the fetus and monitoring of the Indian gestational surrogate mothers is often presented as unproblematic, some do take issue with it. In referring to one commissioning woman, Warner asks, "[w]ould you want this woman owning your womb?"(referring to a Western commissioning woman) (2008). Markens writes, "[i]ncreased regulation of pregnant women symbolized the decreasing reproductive autonomy of pregnant and yet-to-be pregnant women" (2007: 54). Thus the ability of gestational surrogate mothers to make their own choices with respect to surrogate pregnancies is generally taken away. This reduction in the personal autonomy of Indian

gestational surrogate mothers combined with the elevation of the fetus and continual monitoring of the surrogate mothers works to dehumanize these women.

When analysing the public discourse of Indian gestational surrogacy tourism, many ethical issues come to light. While chapter four examined the more postitive 'for' arguments within the ethical master narrative, this chapter has focused on the 'against' side of the ethical debate. On the 'against' side of the ethical master narrative of Indian gestational surrogacy, concerns of nationality and new family formations, exploitation, the understanding of baby making (particularly Indian gestational surrogacy) as a business and the commodification of the body are presented. Other concerns focus on issues which work to dehumanize Indian gestational surrogate mothers, including representations of Indian gestational surrogate mothers as "incubators on legs", a focus on the fetus over the Indian gestational surrogate mother and the constant monitoring of Indian gestational surrogate mothers.

Conclusion

A feminist critical discourse analysis of Indian gestational surrogacy tourism has revealed various discursive representations. Indian gestational surrogate mothers are considered to be in positions of lower social-economic power than the Western couples, particularly Western women and the Western fetus. This can be understood as an extension of world wide hierarchical power structures which dichotomizes the West and the East, first and third world nations. It has been shown that Indian gestational surrogacy tourism has dominant competing discourses focused on either representing this as a positive social development or as a negative social development. This chapter has

examined the social critiques and criticisms of India's developing reproductive tourism industry. Feminist concerns regarding hierarchal power relations are presented throughout the discursive representations.

Conclusion

In order to examine Indian gestational surrogacy tourism, I began with a discussion of the cultural context for reproductive tourism. Chapter one began with a discussion of underlying social ideological beliefs including motherhood and infertility which, in part, can be understood as leading to development of ARTs and in particular the medical development of gestational surrogacy. Ideals of motherhood and infertility have also come to be understood as supporting the development of Indian gestational surrogacy tourism. Furthermore, globalization can be understood as playing an important role in the development of a reproductive tourist industry. Reproductive tourism as it relates to India can be understood as developing out of globalized resources such as worldwide media representations including the internet. Consumerist ideals which promote an 'anything can be bought' ideal have also worked towards a fertility industry which, in the name of a better deal, has come to be outsourced to a country where the ultimate product is produced for the consumer at a lower cost. This has in turn made Indian gestational surrogacy tourism increasingly popular and affordable to the middle class of the West. Indian gestational surrogacy tourism can be understood as a specific example of the world as increasingly becoming "a single place" (Scott and Marshall, 2005: 249). After this, I turned to a discussion of the politics of gestational surrogacy. I examined issues and critiques with respect to gestational surrogacy, many of which can be tied to Indian gestational surrogacy tourism as discussed in chapter three. Dominant critiques of gestational surrogacy include racial and class concerns, exploitation and the

commodification of the body and issues of choice. Legislative responses to gestational surrogacy were discussed and also related to Indian gestational surrogacy tourism.

After an in depth discussion of the social context that Indian gestational surrogacy tourism has developed out of, I turned to an explanation of my theoretical framework for this thesis in chapter two. Part of my guiding influence for this research was to answer the question of why Westerners feel they have the right to go to India in order to hire a gestational surrogate mother. For me, the answer to this now is: predominantly because of the naturalization of the desire to have genetically related children and the fact that the available technology and the Indian prices allow more people to have access to fulfill their personal desires of having genetically related children. The method of my analysis is a feminist critical discourse analysis and I used the master narrative idea as a means to understand the media representation of Indian gestational surrogacy tourism. A feminist critical discourse analysis combined with the use of Downe's idea of the master narrative has uncovered how the discourse of Indian gestational surrogacy is represented. I have found that Indian gestational surrogacy is presented as an ethical master narrative. Within this ethical master narrative, there are particular discursive frames used by supporters and critics of this practice.

It was expected that there would be a clear division between Western and Indian discursive representations. However, this was not found. Both Western and Indian discourse presented Indian gestational surrogacy tourism through an ethical master narrative in which the discursive frames both supported and questioned the use of Indian gestational surrogate mothers. I instead found that there is a clearer division between the

discursive frames either supporting or questioning this practice. It is important to note that within both discourses there were clear presentations of both for and against arguments as well as discursive representations which were not as easily understood to be on either side of the ethical debate.

It appears there is a relatively fair balance of representation between both sides of the ethical perspectives presented in Indian gestational surrogacy tourism. Thus those for and against Indian gestational surrogacy tourism both appear to be strong, powerful groups. However, it was noticed that media accounts were presented by individuals who are generally in positions of social power. Indian gestational surrogate mothers appear to have little voice in the discursive representations, and the voice that they do have is mediated.

Since Indian gestational surrogacy tourism can be understood as an ethical master narrative which positions arguments for and against on opposing sides, my analysis is divided into two chapters in order to reflect this separation. Within the ethical master narrative, discourses on both sides of the ethical debate use many representations in order to present 'the reality' of Indian gestational surrogacy tourism in terms which support their specific social view. In the first part of my analysis, chapter three, I focused on the discourse that presents Indian gestational surrogacy tourism as a positive social development. I examined the discursive representations of the Indian gestational surrogate mothers and the commissioning couples as well as issues of access. Underlying social reasons such as the naturalization of reproduction as well as Indian and Western depictions of desperation, hope and globalization were found to be important factors

which have helped to support and build the reproductive tourist industry as it relates to India. In this chapter I also found that other, more specific, discourses surrounding outsourcing gestational surrogacy to India have become popular justifications. Media representations present India as a last resort destination, one where infertile couples' dreams can come true, and this works to provide hope for desperate and determined couples. Financial concerns as well as governmental and legal issues were also found to help characterize India as 'the place' to travel to in order to obtain gestational surrogacy services. Positive representations of reproductive tourism in India also present the tendency for the Indian Council of Medical Research and fertility clinics to place a particular focus on presenting the child that the surrogate is gestating as not her own. Furthermore, representations of India as a place with an unlimited supply of gestational surrogate mothers were also found to play an important role in India's growing reproductive tourism industry.

Those who argue for the propriety of using Indian gestational surrogate mothers tend to be those Westerners who in fact use, have used, or intend to use the services of Indian gestational surrogate mothers. Such users of Indian gestational surrogacy services often believe that they are in fact helping Indian women. These arguments allude to altruistic ideals as they are presenting Westeners as giving impoverished Indian women a chance at making a 'life changing amount of money'. Hence such depictions tend to focus on a concept of 'women helping women' in an international context. In addition, Indian infertility specialists and the Indian Council of Medical Research who specialize

in gestational surrogacy have come to present Indian gestational surrogacy services as services that help to relieve the symptoms of infertility

Emotional appeals regarding the women who experience infertility are strong representations guiding the reader to place themselves in the position of the infertile. Such appeals are convincing in arguing for the acceptability of Indian gestational surrogacy tourism. The representation of desperation both on behalf of the infertile and the Indian gestational surrogate mothers are also convincing arguments. In presenting an understanding that those involved in gestational surrogacy tourism are desperate, the discourse is able to present this particular instance of reproductive tourism as one which mutually benefits those involved. The representation of the baby not belonging to the gestational surrogate is very important. One of the biggest concerns for commissioning parents is that the gestational surrogate will try to keep the baby. Thus, I feel this representation works to reassure the commissioning couples that this will not happen in India. This aids the representation of India as a 'safer' alternative to Western countries.

In contrast, in chapter four, my analysis moves on to the competing discursive frames within the ethical master narrative that represent this issue in a more critical manner. Here, the discourses work to problematise this social development and to ultimately present the disturbing aspects of Indian gestational surrogacy. Here I began with an analysis of legal and nationality concerns as well as new family formations. I then turned to an examination of the critical discourse that presents exploitative as well as business and commodification of the body concerns. Finally, representations of

dehumanization with respect to choice, fetal focus and the monitoring of Indian gestational surrogates were examined.

Racial issues are of concern on an international scale with respect to the use of Indian gestational surrogate mothers by predominantly Caucasian, Western wealthy couples. Importantly, race was mentioned in particular to describe the women as "Indian" and some mention was made of 'poor Indian women'. My analysis did show that the discourse surrounding reproductive tourism as it relates to India centers more on issues of socio-economic inequality. Since the Indian women are in positions of lower socio-economic status than those hiring their services, the Indian gestational surrogate mothers can be understood as occupying a disadvantageous position of power in comparison to those Westerners using their services. As discussed in chapter one, the literature shows an interconnection between race and socio-economic status which can now be extended to and understood on an international scale. Thus, representations of Indian gestational surrogacy tourism can be understood as part of worldwide unequal power relations particularly as they relate to socio-economic positioning.

Terms used to describe Indian gestational surrogacy tourism such as 'outsourcing the womb', 'wombs for rent' and references made to the Indian gestational surrogates mothers as 'baby factories' and 'incubators' are dehumanizing as they seem to reduce Indian gestational surrogate mothers to their reproductive capabilities. These terms are are also powerful terms used to encourage the reader to understand this practice negatively. The comparison made of human beings as "outsourced", or merely "wombs

for rent" is also one that appeals to human emotions and this manipulation of emotions is used to create social distaste for these services.

I feel that both sides of the ethical debate argue their points convincingly and are both well represented in the discourse. While some particular articles do argue more specifically for one side of the argument, there are some that try to present both sides of the issue. I feel that if the reader reads multiple articles she/he will be able to understand well the positive and negative issues involved, as well as to some extent the reasons why reproductive tourism and Indian gestational surrogacy tourism have developed. The ethics involved clearly make this situation a tough one to deal with and I feel that this is something that is well brought out within the discourse. For instance, how do we legislate one's right to use such technology in order to reproduce or how do we legislate the ways Indian women are allowed to earn money?

While conducting my research and analysis of the use of Indian gestational surrogate mothers by comparatively wealthy Western couples, the topic has become more pronounced in the media. I feel this is an important fact to mention here. My research began with a single article and my initial search provided a fair number of news reports on the subject. However, recently, the number of articles being written on this topic has increased. This suggests that Indian gestational surrogacy tourism is in fact a topic of increasing concern. This in turn suggests that the number of Westerners using these services is increasing and thus Indian gestational surrogacy tourism is beginning to have real world effects on people's lives the world over. This to me warrants further research in order to gain a better understanding of this practice. Reproductive tourism is a

developing social issue and as such little research has been conducted in this area. In an increasingly globalized world which places importance on reproduction it is likely that this industry will continue to grow and develop. Hence a clear understanding as to its driving forces, effects and potential effects world wide is necessary. Further research is needed to uncover what the global implications are, have been and will be. Very little numerical information is currently available to quantify how often this process is occurring thus such quantitative research is necessary. Furthermore, research that actually focuses on the experienced effects of both the Indian women who are acting as gestational surrogates as well as the commissioning couples needs to be conducted to understand the individual social effects. Further research to understand this issue will help not only to determine the size of this industry, but will also help in understanding why this is occurring and can help inform policies and legislation and can help guide decision makers as to how to appropriately deal with this new social development.

Indian gestational surrogacy is presented as an ethical debate and as one that is unlikely to be resolved. The discourse is complex as it presents two competing discursive frames through which we can understand this issue. The multiplicity of arguments, for and against, may leave the reader confused or uncertain as these arguments are often contradictory. Thus while it is understood as an ethical master narrative, one cannot simply understand this issue as a good or bad thing. The concentration of Indian gestational surrogacy tourism from a Western perspective leaves little room to hear the voices of the Indian women themselves and this is a gap in the discourse that needs to be filled.

Downe suggests that we need to rewrite the master script to include women's stories (2006: 567) which may be a strategy that would also be useful if adopted in studies of gestational surrogacy and the "outsourcing of the womb" to India. Perhaps this approach would enable an understanding of Indian gestational surrogacy tourism beyond the ethical debate and in terms other than either for or against. In attempting to understand this issue beyond an ethical debate we may be able to have a clearer understanding of Indian gestational surrogacy tourism. While understanding the ethical support and critiques are important, it is also important to understand this issue as something more, as something that is socially developed. Going beyond the ethical debate may also enable us to learn and study the actual effects, and not just the potential effects, this has and will have in the future.

Since Indian gestational surrogacy tourism is generally presented as an ethical master narrative, it generally does not provide the reader with any other understanding of this issue. For instance, while rhetoric is used to describe the size of this industry, there is no statistical support for this. Overall, in reading the discourse I get the sense that this is occurring frequently, when it may in fact be only occurring in a few instances, at least up until this point. Furthermore, while I do like that the discourse does present both for and against arguments, I feel that it does not provide any kind of in between position. It suggests that one either has to be for or against Indian gestational surrogacy tourism. I feel that this does not adequately reflect the reality of the social world, where opinions are not always black and white, one way or another. The ethical presentation of Indian gestational surrogacy tourism leaves me with many unresolved feelings as to whether or

not it is and should be an acceptable practice. I personally cannot define myself as being on one side or the other of the ethical debate. While I do have a tendency to feel that it is exploitive and that it continues hierarchical power structures, I do feel there is legitimacy in the arguments of the personal experiences of infertile women. I believe that it is inappropriate to exploit the female body, especially when it comes to exploiting their reproductive capabilities, but do not feel I can condemn a woman who understands herself as being desperate to have a child from using these services.

While I can relate to both sides of the ethical debate that is presented on Indian gestational surrogacy, I find it concerning. The difficulty in determining nationally of surrogate children and the recreation of family formations are difficult issues related to surrogacy tourism that I feel create real concern. I find exploitative concerns, the control placed on gestational surrogate bodies and the superseding of the fetus' health over the health of Indian gestational surrogate mothers to be the most convincing and worrisome in the discourse of Indian gestational surrogacy tourism. These arguments sway me towards understanding reproductive tourism as unacceptable practice. However, overall I cannot say that I am for or against Indian gestational surrogacy tourism, but rather that I do feel that there are both positive and negative aspects for those involved. To me, then, it is about weighing the overall good and the overall bad as a better assessment of this issue.

Finally I believe that legislation needs to catch up to this development but have difficulty in deciding how this should be done. If we choose to allow this practice, at a minimum there needs to be safeguards for all involved. Parental and particularly

maternal rights need to be legally defined. Legal decisions need to define the acceptable surrogacy process, for instance outline how the commissioning parents legally become the parents of a surrogate child. Are the surrogate children to be adopted or are they to be legally considered the child of the commissioning parents at birth? Defining this, I think, will avoid further cases like baby Manji. Furthermore, measures need to be taken in order to protect the surrogate mothers' interests. If we decide it is acceptable to pay the Indian gestational surrogates, then we need to determine what an acceptable 'wage' is. We also need to ensure that they are not being coerced into it by familial influence so as to avoid their abuse by family members.

References

Akanksha Infertility Clinic
2002 "Our Team". www.ivfcharotar.com

Andersen, Margaret L and Patricia Hill Collins
2004 "Conceptualizing Race, Class, and Gender: Introduction" *Race, Class and, Gender.* Margaret L. Andersen and Patricia Hill Collins eds. Wadsworth: Toronto 75-98.

Anleu, Sharyn Roach.
1992 "Surrogacy: For Love but Not for Money?" *Gender and Society* 6(1): 30-48.

Assisted Human Reproduction Act, S.C. 2004, c. 2, A-13.4.

Balsamo, Anne
1996 "Chapter Four: Public Pregnancies and Cultural Narratives of Surveillance" *Technologies of the Gendered Body.* Duke University Press: USA 80 – 115.

Barbados Fertility Center
2008 "A Holiday with a purpose" http://www.barbadosivf.org

Barbados Fertility Center
2008 "Personal Correspondence with the Patient Liaison Manager of the clinic"

Barber, Katherine, Heather Fitzgerald, Tom Howell and Robert Pontisso eds.
2005 *Oxford Canadian Dictionary of Current English.* Oxford University Press: Don Mills.

Beckman, Linda J. and S. Marie Harvey
2005 "Current Reproductive Technologies: Increased Access and Choice?" *Journal of Social Issues* 61(1): 1-20.

Beetham, Gwendolyn and Justina Demetriades.
2007 "Feminist research methodologies and development: overview and practical application". *Gender and Development* 15(2).

Ber, Rosalie
2000 "Ethical Issues in Gestational Surrogacy" *Theoretical Medicine and Bioethics* 21 153-169. Kluwer Academic Publishers.

Bhattacharyya, Swasti
2006 *Magical Progeny, Modern Technology. A Hindu Bioethics of Assisted Reproductive Technology.* State University of New York Press: Albany, New York.

Bloom, Marcy
2008 "Need Abortion-Will Travel" Blog. *RH Reality Check: Information and Analysis for Reproductive Health.* http://www.rhrealitycheck.org/blog/2008/02/25/need-abortion-will-travel

Blyth, Eric and Abigail Farrand
2005 "Reproductive Tourism – a price worth paying for reproductive autonomy?"*Critical Social Policy* 25(1): 91-114.

Butler, Patricia A.
2003 *Progress in Reproductive Health Research* No. 63. Ed. Jitendra Khanna 1-8.

Damelio, Jennifer and Kelly Sorensen
2008 "Enhancing Autonomy in Paid Surrogacy" *Bioethics* 22(5) 269-277. Blackwell Publishing Ltd.

Deech, Ruth
2003 "Reproductive Tourism in Europe: Infertility and Human Rights" *Global Governance* 9 425-432.

Dossani, Rafiq
2005 "Globalization and the Offshoring of Services: The Case of India" *Brookings Trade Forum* 241-267.

Downe, Pamela J.
2006 "Strategic Stories and Reflexive Interruptions: Narratives of a "Safe Home" Amidst Cross-Border Sex Work" *Qualitative Inquiry* 13(4) 554-563.

Doyal, Lesley
1987 "Infertility – A Life Sentence? Women and the National Health Service" *Reproductive Technologies: Gender, Motherhood and Medicine.* Michelle Stanworth ed. University of Minnesota Press: Minneapolis 174-190.

Eichler, Margrit
1994 "Reflections on the "Temporary Use of Normally Functioning Uteri" *Misconceptions V.2.* Gwynne Basen, Margrit Eichler, Abby Lippman eds. Voyageur Publishing: Ontario 193-214.

Fairclough, Norman
2006 *Language and Globalization.* Routledge: New York.

Field, Martha A.
1988 Surrogate Motherhood. Harvard University Press. Cambridge, Massachusetts London, England.

Franklin, Sarah
1997 *Embodied Progress: A Cultural Account of Assisted Conception.* Routledge: New York.

Goslinga-Roy, Gillian M.
2000 "Body Boundaries, Fiction of the Female Self: An Ethnographic Perspective on Power, Feminism, and the Reproductive Technologies" *Biotechnology and Culture: Bodies, Anxieties, Ethics.* Paul E. Brodwin ed. Indiana University Press: Indiana 121 – 146.

Grayson, Deborah.
2000 "Mediating Intimacy: Black Surrogate Mothers and the Law" *Biotechnology and Culture: Bodies, Anxieties, Ethics.* Paul E. Brodwin ed. Indiana University Press: Indiana 99 – 120.

Gentleman, Amelia
2008 "India Nurtures Business of Surrogate Motherhood" *The New York Times* March 10. www.nytimes.com

Gillespie, Kerry
2008 "Province Appoints Panel to Help Childless Couples" *The Record (serving Kitchener, Waterloo, Cambridge and the Townships)* July 11.

Gupta, Jyotsna Agnihotri
2006 "Towards Transnational Feminisms: Some Reflections and Concerns in Relation to the Globalization of Reproductive Technologies" *European Journal of Women's Studies.* Sage Publications 13(23).

Hammons, Stacy A.
2008 "Assisted Reproductive Technologies: Changing conceptions of Motherhood?" *The Journal of Women and Social Work.* Sage Publications 23(3) 270-280.

Haworth, Abigial
2008 "Surrogate Mothers: Womb for Rent" *Marie Claire.* http://www.marieclaire.com/world/articles/womb-rent-india

Indian Council of Medical Research
2006 Ethical Guidelines for Biomedical Research on Human Participants. New Delhi.http://icmr.nic.in/

Indian Council of Medical Research
2005 National Guidelines for Accreditation, Supervision and Regulation of ART clinics in India. New Delhi. http://icmr.nic.in/

Ikemoto, Lisa C.
1996 "The In/Fertile, the Too Fertile, and the Dysfertile" *Hastings Law Journal* 47: 1007-1061.

Jennings, James and Louis Kushnick
2004 "Poverty as Race, Power, and Wealth" *Race, Class and, Gender.* Margaret L. Andersen and Patricia Hill Collins eds. Wadsworth: Toronto 154-158.

Johnson v. Calvert
1993 Pacific Reporter 2d Series 851 P.2d 776-801.

Jorgensen, Henrik Kjeldgaard
2000 "Paternalism, Surrogacy, and Exploitation" *Kennedy Institute of Ethics Journal* 10 (1), 39-58. The Johns Hopkins University Press.

Kelly, Deirdre M.
1996 "Stigma Stories: Four Discourses About Teen Mothers, Welfare, and Poverty" *Youth & Society* 27(4): 421-449.

Lazar, Michelle M.
2005 "Politicizing Gender in Discourse: Feminist Critical Discourse Analysis as Political Perspective and Praxis" *Feminist Critical Discourse Analysis: Gender, Power and Ideology in Discourse* Michelle M. Lazar ed. Palgrave Macmillan: New York 1-28.

Lee, Robert G. and Derek Morgan
2001 Human Fertilisation & Embryology: Regulating the Reproductive Revolution. Blackstone Press Limited: London, U.K.

Locke, Terry
2004 *Critical Discourse Analysis.* Continuum International Publishing Group: New York.

Lowry, Deborah Wilson
2004 "Understanding Reproductive Technologies as A Surveillant Assemblage: Revisions of Power and Technoscience" *Sociological Perspectives* 47(4): 357 – 370.

MacDonald, Maggie
1994 "Procreation and the Creation of Meaning: Studying The New Reproductive Technologies" *Misconceptions V.2.* Gwynne Basen, Margrit Eichler, Abby Lippman eds. Voyageur Publishing: Ontario 86-98.

McTeer, Maureen A.
1995 "A Role for Law in Matters of Morality" *McGill Law Journal* 40 893-903.

Markens, Susan
2007 *Surrogate Motherhood and the Politics of Reproduction.* University of California Press: Berkeley and Los Angeles, California.

Mautner, Gerlinde
2008 "Analyzing Newspapers, Magazines and Other Print Media" *Qualitative Discourse Analysis in the Social Sciences.* Ruth Wodak & Michal Krzyzanowski eds. 30-53.

Menzies, Heather
1994 "The Social Construction of Reproductive Technologies and of Choice" *Misconceptions V.2.* Gwynne Basen, Margrit Eichler, Abby Lippman eds. Voyageur Publishing: Ontario 17-32.

Miall, Charlene E.
1986 "The Stigma of Involuntary Childlessness" *Society for the Study of Social Problems* 33(4): 268-282.

Miller, Tina
2005 *Making Sense of Motherhood: A Narrative Approach.* Cambridge University Press: Cambridge

Millett, Kate
1970 *Sexual Politics.* Doubleday & Company, Inc.: New York.

Momsen, Janet Henshall
2004 *Gender and Development*. Routledge: Canada.

Nijher, Jaspreet
2008 After Gujarat, rent-a-womb biz booms in Punjab" *The Times of India*. http://timesofindia.indiatimes.com

Oakley, Ann
1987 "From Walking Wombs to Test-Tube Babies" *Technologies: Gender, Motherhood and Medicine*. Michelle Stanworth ed. University of Minnesota Press: Minneapolis 36-56.

Pattillo-McCoy
2004 "Black Picket Fences: Privilege and Peril among the Black Middle Class" *Race, Class and, Gender*. Margaret L. Andersen and Patricia Hill Collins eds. Wadsworth: Toronto 158-165.

Pedersen, Jorgen Dige
2008 *Globalization, Development and the State: The Performance of India and Brazil since 1990*. Palgrave Macmillan: New York.

Pennings, Guido
2004 "Legal Harmonization and Reproductive Tourism in Europe" *Human Reproduction* 19(12) 2689-2694.

Pfeffer, Naomi
1987 "Artificial Insemination, In-vitro Fertilization and the Stigma of Infertility" *Reproductive Technologies: Gender, Motherhood and Medicine*. Michelle Stanworth ed. University of Minnesota Press: Minneapolis 81-97.

Quéniart, Anne
1992 "Risky Business: Medical Definitions of Pregnancy" *The Anatomy of Gender Women's Struggle for the Body*. Dawn H. Currie and Valerie Raoul eds. Carleton University Press: Ottawa 161-174.

Ragoné, Heléna
2000 "Of Likeness and Difference: How Race is Being Transfigured by Gestational Surrogacy" *Ideologies and Technologies of Motherhood: Race Class Sexuality Nationalism*. Heléna Ragoné and France Winddance Twine eds. Routledge: New York 56 – 75.

Rathgeber, Eva M.
1990 "WID, WAD, GAD: Trends in Research and Practice" *The Journal of Developing Areas* 24. Western Illinois University 489-502.

Reilly, Dan R.
2007 "Surrogate pregnancy: a guide for Canadian Prenatal health care providers" *Canadian Medical Association Journal* 174(4) 483-485.

Ritzer, George
2004 *The McDonaldization of Society Revised New Century Edition.* Pine Forge Press, A Sage Publications Company: California.

Rothman, Barbara Katz
1989 *Recreating Motherhood Ideology and Technology in a Patriarchal Society.* W.W. Norton & Company: New York.

Rothman, Barbara Katz
2000 *Recreating Motherhood.* Rutgers University Press: New Brunswick, New Jersey.

Schwartz, Adria
1994 "Taking the Nature Out of Mother" *Representations of Motherhood.* Donna Bassin, Margaret Honey and Meryle Mahrer Kaplan eds. Yale University Press: New Haven 240-255.

Scott, John & Gordon Marshall eds.
2005 *Oxford Dictionary of Sociology.* Oxford University Press: Toronto.

Scritchfield, Shirley A.
1995 "The Social Construction of Infertility: From Private Matter to Social Concern" *Images of Issues: Typifying Contemporary Social Problems Second Edition.* Joel Best ed. Walter de Gruyter, Inc: New York 131 - 146.

Segal, Adam
2008 "Autonomy, Security, and Inequality: China, India, the United States, and the Globalization of Science and Technology" *Technology in Society* 30 423-428.

Sethna, Christabelle, Marion Doull
2007 "Far From Home? A Pilot Study Tracking Women's Journeys to a Canadian Abortion Clinic" *Women's Health* August: 640-647).

Sharp, Lesley A.
2000 "The Commodification of the Body and Its Parts" *Annual Review of Anthropology* (29) 287-328.

Shevory, Thomas C.
2000 Body/Politics: Studies in Reproduction, Production, and (Re)Construction. Praeger Publishers: Westport, CT.

Shiva, Vandana
1993 "Reductionism and Regeneration: A Crisis in Science" *Ecofeminism.* Maria Mies and Vandana Shiva. Fernwood Publishing: Halifax 23-35.

Singh, Mahendra Kumar
2007 "New laws to rein in 'womb business'" *The Times Of India.* www.timesofindia.indiatimes.com

Sistare, Christine T.
2001 "Reproductive Freedom and Women's Freedom: Surrogacy and Autonomy" *Bioethics, Justice and Health Care.* Eds. Wanda Teays and Laura M. Purdy. Wadsworth, Nelson Thomson Learning: Toronto, Ontario.

Spar, Debora L.
2005 "For Love and Money: The Political Economy of Commercial Surrogacy" *Review of International Political Economy.* Routledge 12(2) 287-309).

Spar, Debora L.
2006 The Baby Business. *Harvard Business School Press.* Boston: 1-96.

Stanworth, Michelle
1987 "Reproductive Technologies and the Deconstruction of Motherhood" *Reproductive Technologies: Gender, Motherhood and Medicine.* Michelle Stanworth ed. University of Minnesota Press: Minneapolis 10-35.

Stephenson, Christina
2009 "Reproductive Outsourcing to India: WTO Obligations in the Absence of US National Legislation" *Journal of World Trade* 43(1): 189-208.

SurroGenesis USA, INC.
2007 "Fees Surrogacy" www.surrogenesisusa.com/

Van Balen, Frank and Marcia C. Inhorn
2002 "Interpreting Infertility: A View from the Social Sciences" *Infertility around the Globe: New Thinking on Childlessness, Gender, and Reproductive Technologies.* Marcia C. Inhorn and Frank Van Balen eds. 7 – 32.

Van Den Akker, Olga
2002 *The Complete Guide to Infertility: Diagnosis, treatment, options.* Free Association Books: London, England.

Vandervort, Lucinda
2006 "Reproductive Choice: Screening Policy and Access to the Means of Reproduction" *Human Rights Quarterly* 28 438-464. The John Hopkins University Press.

Warner, Judith
2008 "Outsourced Wombs" The New York Times Online. www.nytimes.com/#

Widge, Anjali
Undated (a)"Sociocultural attitudes towards infertility and assisted reproduction in India" *World Health Organization Website:* www.who.int/en/

Widge, Anjali
Undated (b)"Infertility" Excerpt from Unpublished manuscript. *World Health Organization Website:* www.who.int/en/

Wilkinson, Stephen
2003 "The Exploitation Argument Against Commercial Surrogacy" *Bioethics* 17(2) 169-187. Blackwell Publishing Ltd.

Wodak, Ruth
2008 "Introduction: Discourse Studies –Important Concepts and Terms" *Qualitative Discourse Analysis in the Social Sciences.* Ruth Wodak & Michal Krzyzanowski eds. 1-29.

Woliver, Laura R.
1996 "Reproductive Technologies, Surrogacy Arrangements, and the Politics of Motherhood" *Mothers in Law: Feminist Theory and the Legal Regulation of Motherhood.* Columbia University Press: New York 346-359.

Woliver, Laura R.
2002 *The Political Geographies of Pregnancy.* University of Illinois: Urbana and Chicago.

Young, Alison Harvison
2001 "Legislative Responses to New Reproductive Technologies" *Science, Truth and Justice*. Dean Joost Blom and Hélène Dumont eds. Les Éditions Thémis Inc: Montreal 37-51.

Article References

Akanksha Infertility Clinic
2009 www.ivfcharotar.com

Ali, Lorraine and Raina Kelley
2008 "The Curious Lives of Surrogates" *Newsweek*, April 7.

Associated Press, The
2007 "Wombs for rent: growth of commercial surrogacy" *The Spec.com*, December 31. www.thespec.com

Associated Press, The / The Canadian Press
2008 "Surrogate child custody case in limbo in India after Japanese parents divorce" *The Kitchener Waterloo Record*, August 5. http://news.therecord.com/

Bhandari, Prakash (a)
2008 "Conceived in Japan, abandoned in Jaipur" *The Times of India*, August 6. www.timesofindia.indiatimes.com

Bhandari, Prakash (b)
2008 "Surrogate baby case takes new turn" *The Times of India*, August 7. www.timesofindia.indiatimes.com

Bhandari, Prakash (c)
2008 "Hope floats for little Manji" *The Times of India*, October 11. www.timesofindia.indiatimes.com

Bhandari, Prakash (d)
2008 " 'Identity' for little Manji" *The Times of India*, October 18. www.timesofindia.indiatimes.com

Bhatia, Shekhar
2004 "Let our surrogate twins stay with us" *London Evening Standard*, July 26. www.thisislondon.co.uk

Bhatia, Shekhar (a)
2009 "Mumbai clinic sends couple email: You have a boy and girl. Congratulations" *London Evening Standard*, May 20. www.thisislondon.co.uk/standard/

Bhatia, Shekhar (b)
2009 "Investigation: Surrogate baby delivered every 48 hours" *London Evening Standard*, May 20. www.thisislondon.co.uk/standard/

Bhatia, Shekhar (c)
2009 "Couple back home with twins after months of legal battles" *London Evening Standard*, June 8. www.thisislondon.co.uk/standard/

Bhatia, Shekhar and Isabel Oakeshott
Date unknown (printed August 9, 2008)
"Woman gives birth to her own grandchildren" *Mail Online*. www.dailymail.co.uk

Bhatia, Shyam
2004 "Woman gives birth to grandkids"*rediff.com*, January 30. www.rediff.com

Braid, Mary
2005 "He was never my son" *The Independent UK*, March 22. www.independent.co.uk

Chopra, Anuj
2006 "Childless couples look to India for surrogate mothers" *The Christian Science Monitor*, April 3. www.csmonitor.com/

Chu, Henry
2006 "Wombs for Rent, Cheap" *Los Angeles Times*, April 19. www.latimes.com/

Cole, Brian
2008 "Surrogacy Clinics in India – a New Twist on Outsourcing" *Docshop.com*, February 1. www.docshop.com/

Dolnick, Sam
2007 "Giving birth becomes the latest job outsourced to India as commercial surrogacy takes off" *Commercial Appeal.com*, December 30. www.commercialappeal.com

Dyer, Clare
2007 "Surrogacy loophole that let 20 babies be taken" *Guardian UK*, December 5. www.guardian.co.uk

Gazze, Mary
2007 "Canada: destination for infertile couples" *The Globe and Mail*, June 26. www.theglobeandmail.com/

Gazze, Mary
2009 "Canada: destination for infertile couples" *The Globe and Mail*, April 3. www.theglobeandmail.com/

Gentleman, Amelia
2008 "India Nurtures Business of Surrogate Motherhood" *The New York Times*, March 10. www.nytimes.com

Ghura, Pritika
2006 "Womb for sale @ Rs 2 lakh" *The Times of India*, September 3. www.timesofindia.indiatimes.com

Goodchild, Sophie
2009 "Parents who fire foreign surrogates 'risk losing children'" *London Evening Standard*, May 28. www.thisislondon.co.uk/standard/

Goodman, Ellen
2008 "Checking the womb rates in India" *Commercial Appeal.com*, April 13. www.commercialappeal.com

Haworth, Abigail
2009 "Surrogate Mothers: Womb for Rent" *Marie Claire*. www.marieclaire.com

Horsey, Kirsty Dr.
2004 "Supergran surrogacy" *IVF.net,* February 3. www.ivf.net/

Horsey, Dr. Kirsty Dr.
2005 "Reproductive tourism should be seen as a 'safety valve'"*IVF.net,* June 27. www.ivf.net/

Iyer, Malathy
2008 "Draft law tightens surrogacy norms" *The Times of India*, September 30. www.timesofindia.indiatimes.com

Jha, Sachchidanand
2003 "Surrogacy taking shape of a profession: Expert" *The Times of India*, May 11. www.timesofindia.indiatimes.com

Jones, Sam
2004 "Visa for twins born to their grandmother" *Guardian UK,* July 27. www.guardian.co.uk/

Kahn, Michael
2008 "Experts say reproductive tourism a growing worry" *Reuters UK*, July 24. http://uk.reuters.com

Kannan, Shilpa
2009 "Regulators eye India's surrogacy sector" *BBC News*, March 18. http://newsvote.bbc.co.uk

Kaur, Gagandeep
2007 "Outsourcing a womb" *The Hindu Business Line*, April 6. www.thehindubusinessline.com/

Leigh, Suzanne
2005 "Reproductive 'tourism'" *USA Today*, February 2. www.usatoday.com

Macleans
2007 "Outsourcing life itself: what India teaches us" *From the Editors*, July 2. www.macleans.ca

Mahapatra, Dhananjay
2008 "Japanese surrogate baby Manji to stay with grandmother: SC" *The Times of India*, August 15. www.timesofindia.indiatimes.com

Mahapatra, Dhananjay
2009 "Baby Manji's case throws up need for law on surrogacy" *The Times of India*, August 25. www.timesofindia.indiatimes.com

Medical Tourism Corporation
2009 www.medicaltourismco.com

Mendick, Robert (a)
2009 "Baby Daisy is worth every penny" *London Evening Standard*, May 6. www.thisislondon.co.uk/standard/

Mendick, Robert (b)
2009 "A surrogacy clinic in India is advertising babies for sale to single men in Britain" *London Evening Standard*, June 8. www.thisislondon.co.uk/standard/

Mendick, Robert (c)
2008 "Single men buying children for £15,000 at 'baby factory'"*London Evening Standard*, June 8. www.thisislondon.co.uk/standard/

Mendick, Robert and Shekhar Bhatia
2009 "Couple buy child from India 'baby factory'" *London Evening Standard*, May 6. www.thisislondon.co.uk/standard/

Narayan, Pushpa
2009 "Out-of-job women turn to surrogacy" *The Times of India*, March 12. www.timesofindia.indiatimes.com

Nijher, Jaspreet
2008 "After Gujarat, rent-a-womb biz booms in Punjab" *The Times of India*, January 27. www.timesofindia.indiatimes.com

Nolen, Stephanie (a)
2009 "Desperate Mothers fuel India's 'baby factories'" *The Globe and Mail*, February 13. www.theglobeandmail.com

Nolen, Stephanie (b)
2009 "Draft law falls short, critics say" *The Globe and Mail*, February 13. www.theglobeandmail.com

Oberoi, Radhika
2009 "Surrogacy gives birth to new hope" *The Times of India*, February. www.timesofinida.indiatimes.com

Parker, Randall
2008 "Baby Surrogacy In India Legal And Growing" *Future Pundit*, March 15. www.futurepundit.com

Prasad, Raekha
2008 "The fertility tourists" *Guardian UK,* July 30. www.guardian.co.uk

Ramesh, Randeep
2006 "British couples desperate for children travel to India in search of surrogates" *Guardian UK*, March 20. www.guardian.co.uk/

Redfearn, Suz
2007 "Pursuing a Baby to the Ends of the Earth" *Washington Post*, January 14. www.washingtonpost.com/

Rotunda – The Center for Human Reproduction
2009 www.iwannagetpregnant.com

Roy, Amit
Date unknown (printed August 9, 2009)
"Best thing I've ever done, says Grand-mom – Birth dream comes true" *The Telegraph*. http://telegraphindia.com

Schulz, Sandra
2008 "In India, Surrogacy Has Become a Global Business" *Spiegel Online*, September 25. www.spiegel.de

Scott, Amy
2007 " 'Wombs for rent' grows in India" *Marketplace*, December 27. http://marketplace.publicradio.org

Sharma, Abhinav
2008 "Centre drafting surrogacy legislation" *The Times of India*, August 9. www.timesofindia.indiatimes.com

Sharma, Radha
2008 "Anand back in focus as surrogacy capital" *The Times of India*, August 9. www.timesofindia.indiatimes.com

Sharma, Radha
2009 "Surrogacy stays within the great Indian family" *The Times of India,* January 4. www.timesofinida.indiatimes.com

Sidner, Sara
2008 "Surrogate baby stuck in legal limbo" *CNN (Asia)*, August 12. www.cnn.com/

Singh, Harmeet Shah
2008 "Japanese girl born to Indian surrogate arrives home" *CNN (Asia)*, November 2. www.cnn.com/

Singh, Kumar
2007 "New laws to rein in 'womb business'" *The Times of India*, October 31. www.timesofindia.indiatimes.com

Subramanian, Sarmishta
2007 "Wombs for rent" *Macleans*, July 2. www.macleans.ca

The Oprah Winfrey Show
2008 "Lisa Ling Investigates: Wombs for Rent" *Harpo Productions, Inc.,* July 10.

Unknown Author
2004 "Twins for surrogate grandmother" *Intended Parents Inc.,* January 30. www.intendedparents.com

Unknown Author
2005 "Divorced man adopts surrogacy" *The Times of India*, October 4. www.timesofindia.indiatimes.com

Unknown Author
2006 "Wombs for rent in a hamlet of hope" *The Asian Pacific Post*, March 9. www.asianpacificpost.com

Unknown Author
2007 "Readerspeak: Surrogacy should be brought under law" *The Times of India*, September 4. www.timesofindia.indiatimes.com

Unknown Author
2007 "Surrogate motherhood in India" *News-Medical.Net*, February 7. www.news-medical.net

Unknown Author
2008 "Outsourcing to India eggs and fetuses" *Community Action*, January 23, 23: 5, 1-7.

Unknown Author
2008 "Counter View: Renting a womb is morally wrong" *The Times of India*, February 5. www.timesofindia.indiatimes.com

Unknown Author
2008 "Renuka for strict law on surrogacy" *The Times of India,* June 29. www.timesofindia.indiatimes.com

Unknown Author
2008 "Japanese baby finally gets birth certificate" *The Times of India*, August 10. www.timesofindia.indiatimes.com

Unknown Author
2008 "Baby Blues" *The Times of India*, August 11. www.timesofindia.indiatimes.com

Unknown Author
2008 ""Legalise [sic] Surrogacy in India" said; [sic] Students of School of Excellence, Chennai, Winner of The First National Moot Court Competition On Surrogacy Held At Rizvi Law Collge [sic], Mumbai" *India Prwire[sic]*, August 25. www.indiaprwire.com

Unknown Author
2008 "Manji plea to go home: SC leaves decision to Centre" *The Times of India*, September 16. www.timesofindia.indiatimes.com

Unknown Author
2008 "Finally, baby Manji flies to papa in Japan today" *The Times of India*, October 31. www.timesofindia.indiatimes.com

Unknown Author
2009 "Despite ethical hitches, surrogacy thrives in India" *IBNLive*, May 20. http://ibnlive.in.com

Unknown Author
2009 Surrogacy is no business, it's a need: Experts" *The Times of India*, February 19. www.timesofindia.indiatimes.com

Utpat, Aditi
2009 "Medical fraternity backs surrogacy bill" *The Times of India*, January 5. www.timesofindia.indiatimes.com

Wade, Matt
2009 "India the surrogate mother country for Westeners" *The Age.com.au*, January 31. www.theage.com.au

Warner, Judith
2008 "Outsourced Wombs" *The New York Times*, January 3. www.nytimes.com